the MODERN HOSPITAL

VOLUME 61 OCTOBER 1943 NUMBER 4

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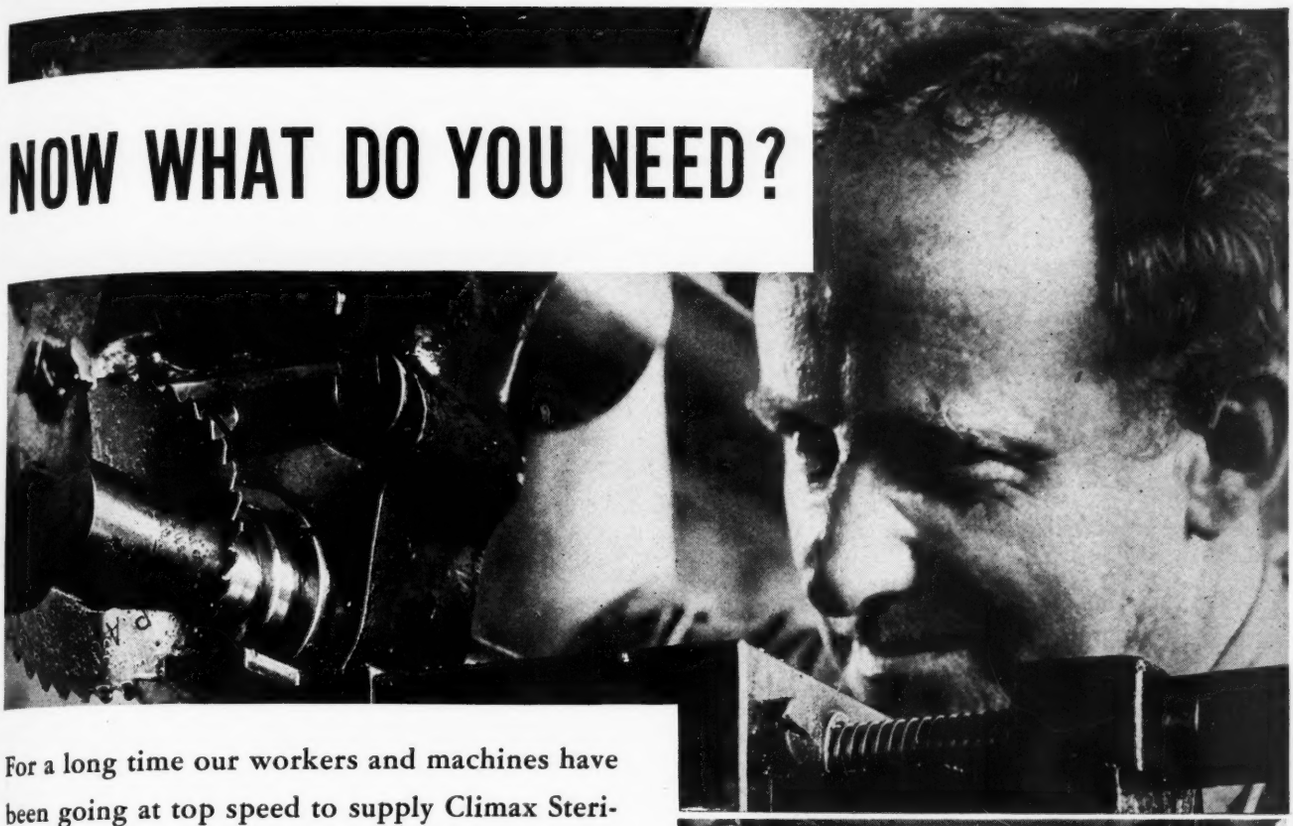

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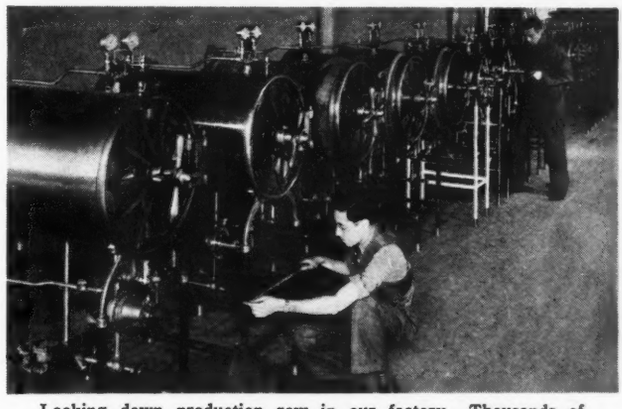

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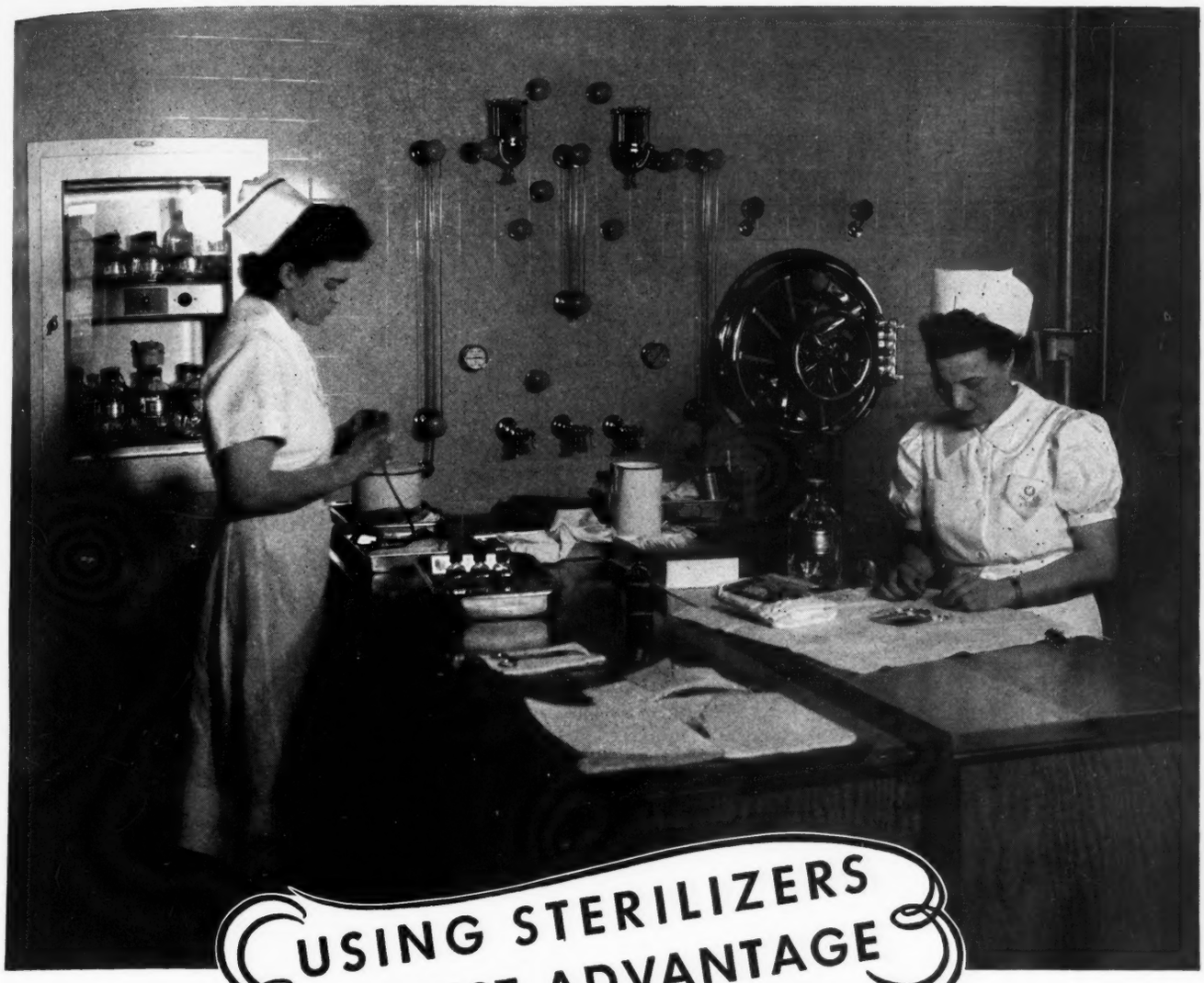

USING STERILIZERS TO BEST ADVANTAGE

Above: A modern central service room at St. Joseph's Hospital, Elgin, Illinois.

Since wartime conditions limit the supplying of new sterilizers to civilian hospitals, obviously the best solution for the present is to utilize to best advantage the existing equipment in the hospital. In this connection, the advantages of a central sterilizing and supply room in the hospital are forcefully emphasized.

Centralization results in marked economy of materials, supplies, equipment, personnel, and supervision. Autoclaves, technical equipment, and supplies can be grouped in one location under centralized responsibility and will serve all departments and floors of the hospital, giving full time use when necessary.

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EDITORIAL BOARD

Mother and Baby

ARE DOING WELL

NOTHING could be more comforting to an apprehensive family than the doctor's assurance that mother and baby are doing well. Modern medical practice, supported by therapeutic agents unknown a generation ago, makes childbirth a relatively safe experience.

In many hospitals and clinics the administration of 'Ergotrate' (Ergonovine Maleate, Lilly) to limit postpartum hemorrhage and to accelerate uterine involution is now a routine procedure. ELI LILLY AND COMPANY, *Indianapolis 6, Indiana, U.S.A.*

BUY WAR BONDS AND STAMPS

THE ROVING REPORTER

Protecting the Doctors

Only two doctors are left to serve two fair-sized towns and the well-populated Puyallup Valley of western Washington. New people are moving in every day to work in the shipyards and war factories near by—new people with no prior claim on the doctors' time.

Under their staggering schedules the doctors were not getting enough sleep to keep them going, so recently they clamped down on night calls.

That was the signal for the community hospital—Puyallup General—to "rise and shine" and rise and shine it did. Night calls for medical service now come to the hospital. The seriously ill are admitted as emergency patients if there is room and the graduate nursing staff takes over.

In cases of abdominal pain an ice bag is applied, the temperature is taken and a blood count is made. The results of the temperature reading and the blood count determine whether or not the hospital calls the sleeping staff man from his bed. When there is apparently no risk, the patient keeps his ice bag and gets nursing care until the doctor examines him in the morning.

In a variety of cases the doctor at his bedside telephone prescribes to the nurse the temporary treatment to be followed.

For emergencies, such as cuts not requiring sutures, the nurses do the cleaning, disinfecting and dressing of the wounds and the doctor inspects the job next morning.

When no beds are available even for emergencies, the hospital tells the patient what to do until the doctor arrives in the morning. If the symptoms sound serious, the hospital summons the doctor from his sleep.

Mothers Go Home Early

In these war days when maternity departments overflow so that, first, private rooms become semiprivate, then maternity patients are segregated on another floor and, finally, beds must be placed in the maternity department corridor, some mother of six or eight days' standing looks out from her comfortable bed to behold a newer mother sheltered only by a screen and says:

"I feel well enough to go home. Why can't I, so that that poor girl may have my bed?"

If the kindhearted patient's doctor thinks the risk in the mother's case is negligible, she and her infant go home and one less bed blocks the corridor.

No harm has yet come from the earlier discharge of these unselfish, carefully examined patients and it helps to drain some of the pressure off the Harrison Memorial Hospital at Bremerton, Wash. This big new naval hospital can't serve all the wives of officers and men so the 135 bed civilian hospital, already overtaxed and understaffed, must stretch its accommodation to new limits.

"Living In" From Choice

"Living in" is something no hospital employe loves—if it's compulsory.

The privilege of making up her own mind on this subject helps to explain the general air of employe well-being that characterizes Everett General Hospital, Everett, Wash. That—and a pastry cook whose pies and cakes put everyone's but mother's to shame.

The only members of the staff who must live in the hospital, under the present setup, are the assistant superintendent, the dietitian, the technician and the pharmacist.

The meat shortage has brought about the serving at Everett General of fish

Perhaps We Can Help You Find the Answer

For more than a half-century it has been our privilege to supply hospitals throughout this nation with high quality textiles. Our lengthy experience as specialists in this field may be of particular value to you now . . . may enable us to aid you in unexpected ways.

We are endeavoring to meet hospital requirements as completely and promptly as possible. Shortages will doubtless increase with the mounting war effort . . . but there are usually answers to every question and perhaps we can help you find them.

Your inquiries are invited. Please address Dept. M10.

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Superintendent Is a Farmer!

No type of knowledge comes amiss to a hospital superintendent. H. L. Gleckler, superintendent of Wesley Hospital, Wichita, Kan., suddenly found himself responsible for the seeding and harvesting of the 1943 high protein wheat crop on a 640 acre hospital farm, much of which is under cultivation. The former tenant left too late to find another so farm management was added to Mr. Gleckler's already busy schedule.

Now the results can be told. The yield is 6309 bushels, all testing a good No. 1, the largest crop that has been produced on the farm since it was given to Wesley Hospital in 1928.

A new tenant will take over next year but in the meantime Mr. Gleckler has laid plans for 160 acres to lie fallow in 1944, another quarter section will be grass and the remaining 320 acres will be reseeded to wheat.

Intern, a College President

Another unusual situation at Wichita's Wesley lies in the fact that one of its new interns is president of Central College of McPherson, Kan. Dr. Orville S. Walters, the intern, will give five days a week to the hospital and the rest of his time to the college. Doctor Walters did not serve an internship when he was graduated from St. Louis University Medical School in 1939 but accepted the offer of the college presidency, as he was both a Ph.D. and an ordained minister of the Free Methodist Church. He is now answering the nation's call for medical manpower.

Ministers to the Rescue

Add Paterson General, Paterson, N. J., to the steadily increasing number of hospitals in which men are assisting as volunteers. This time it is a group of ministers who have come to the hospital's aid by pinch-hitting for ambulance drivers who have joined the armed forces. When the emergency was brought to the attention of the Ministers' Association members got busy, with the result that today eight of them have taken over the night shift from 10 until 8 in the morning. Sunday evening proves no exception. Just as soon as he finishes his service at his church, the minister whose turn it is dashes to the hospital.

No Prejudice Here

Is Dixie Hospital, Hampton, Va., unique in the nation in having a colored nursing staff for white patients? Nancy D. Jenkins, director of nursing service at Hampton, thinks it possibly is.

From none of the hospital's 165 beds has there ever risen any race-prejudiced complaint about service from this group of kindly and ambitious girls. Of course, cries periodically emerge from the 35 bassinets but the traditionally comforting voice and hands of the colored nurse are now reenforced by newly acquired skills of hand so that all goes happily in the nursery.

Miss Jenkins and the hospital administration are looking forward to a four year course for these girls at Hampton Institute.

Japanese Nurses Serve Well

Five nurses representing another racial minority are finding congenial work at Madison General Hospital, Madison, Wis., where Supt. Grace T. Crafts has opened the door to Japanese girls recently released from a relocation center.

Three graduate nurses—college girls these—are doing excellent work and are meeting no discourtesies from grateful patients. Now two alert Japanese students have been admitted to Madison General's reopened school of nursing.

Miss Crafts serves on a committee for placing Japanese girls and her success in amalgamating five of them into the hospital family should lead other hospitals to consider this reservoir of trained talent.

READER OPINION

Shocked by "Palpable Prejudices"

Sirs:

May I comment on your editorial "Reactionaries in the Saddle" appearing in the August issue?

The palpable prejudices expressed in this editorial reveal with rather shocking clarity the fact that a serious schism is developing between the organized hospital world and organized medicine. I am sure that most of us are most anxious to avoid any such unfortunate development.

In your first paragraph you denounce the proposals for compulsory hospital insurance and complain that such a system would place voluntary hospitals under the control of the Social Security Board whose "slightest wish would be our command." Your statement that "the whole character of the voluntary hospital will change" is undoubtedly true.

Does it occur to you that precisely the same reasons provoke the medical profession's objections to the tendency for hospital corporations to control the practice of medicine? The "tattered flag" to which you refer in the next paragraph has become tattered because hospitals are apparently bent upon changing the whole character of private medicine practice and because doctors recognize an unmistakable trend toward a condition in which the hospital's slightest wish would be their command.

I quite agree that every effort should now be concentrated against the federal control of hospitals. I submit that the medical profession also has a legitimate interest in bending every effort to avoid allowing the hospital to gain control of medicine.

When the house of delegates of the American Medical Association enunciates principles opposing the invasion and control of medicine by hospitals, you resort to political pettifoggery by attributing the action to extremists.

I believe that I can safely assure you that your hope that these extremists constitute only a minority is a vain one. It has always been my understanding that the house of delegates of the American Medical Association was a truly democratic body in which the majority ruled.

The truth of your statement that the A.M.A. trustees do not subscribe to the action of the house of delegates is questionable but irrelevant. The house of delegates of the A.M.A. is the voice of American medicine and its actions express the will and the opinions of the organized profession.

It may be true that hospitals and Blue Cross plans will serenely "go forward serving the public in newer and better ways" for, as the house of delegates has stated, it is obvious that the hospitals intend to pursue these newer ways regardless of the wishes and the demands of the medical profession.

It is for these reasons that I dare say the tattered flag to which you contemptuously refer will continue to be waved and the medical profession will continue to wage a relentless fight against attempts by hospitals to dominate medicine and to extend their prerogatives in such a manner as to result in fundamental changes in the present system of medical practice.

Mac F. Cahal
The American College of Radiology
Chicago

Liked Editorial

Sirs:

I like your editorial in the August issue, "Rectionaries in the Saddle." I am glad you published it.

Frank J. Walter
President
American Hospital Association

Congratulations

Sirs:

Congratulations on the August issue, as to both its content and the new dress of some of the pages.

E. A. van Steenwyk
Associated Hospital Service of Philadelphia

Mental Hospital Helped

Sirs:

The MODERN HOSPITAL has been very helpful in the difficult task of administering a mental hospital during this trying period. I have been able to get a great many ideas from it that are useful and I wish to congratulate you and your associates on the splendid magazine that you are turning out. It is a real contribution.

William A. Bryan, M.D.
Superintendent
Norwich State Hospital
Norwich, Conn.

Another Reader Pleased

Sirs:

I want to congratulate you on the August issue of MODERN HOSPITAL. It certainly was a prize number and gave us a great deal of the kind of information we need regarding the Federal Hospital Program.

Ray M. Amberg
University of Minnesota Hospitals
Minneapolis

SMALL HOSPITAL QUESTIONS

Conducted by Gladys Brandt, R.N., Children's Free Hospital, Louisville, Ky.; Jewell W. Thrasher, R.N., Frasier-Ellis Hospital, Dothan, Ala.; William B. Sweeney, Windham Community Memorial Hospital, Willimantic, Conn.; A. A. Aita, San Antonio Community Hospital, Upland, Calif.; William J. Donnelly, Greenwich Hospital, Greenwich, Conn., and others

Cellucotton for Nonsterile Pads?

Question: What are other hospitals doing about the use of cellucotton for nonsterile (large) pads?—D.L.R., Kan.

ANSWER: The question is not clear in that it is not known whether the term "pads" refers to perineal pads or the abdominal type, *i.e.* those used for clean postoperative cases or for semi- or heavy drainage cases.

To answer both specifically, we have recently changed from the cellulose-filled type of napkin to a larger and more efficient cotton-filled type, and in the case of abdominal pads are also using a ready-made type which is constructed of both cotton and cellucotton with a nonabsorbent backing.

In a study made recently by one of the surgical dressing manufacturers it was determined that there are four principal qualities of absorbency: (1) rate of speed; (2) capillary action; (3) retentiveness, and (4) capacity.

In comparing the absorbency qualities of cotton and cellucotton, it was found that one might be much more efficient than the other insofar as one or two of these four points are concerned. Therefore, for abdominal pads we are using a ready-made type that contains both cotton and cellucotton which gives us the maximum efficiency.

We use the cotton-filled type of obstetrical pad (12 inches long by 3½ inches wide) because we have found that the cotton filler retains the drainage better; there is no leakage out the sides or penetration through the top, such as occurs with the cellulose-filled type. Furthermore, after autoclaving, cotton retains its original softness and white color, whereas cellucotton becomes stiff and harsh and turns brown.

Consequently, the cotton-filled pad is much more comfortable to the patient and, being 12 inches long, eliminates the need for the usual two pads, thus saving money by reducing the number of pads required.

To sum up, we believe that, while occasionally there may be a few specific cases where cellucotton may be used advantageously, either a combination of cellucotton and cotton or just a cotton filler will give the most efficient results.—ELIZABETH ODELL, R.N.

Charting Tuberculosis Transfers

Question: When a patient is admitted for diabetic control and tuberculosis is found present, necessitating transfer to another hospital, how should the patient's chart be signed as to result?—H., Conn.

ANSWER: In such an instance your chart will indicate (1) the result for the final diagnosis which would be the condition for which the patient was being treated in your hospital and (2) the result for the tuberculosis. For statistical purposes the result of the condition for which the patient was treated in your hospital would be used.—MRS. EDNA HUFFMAN.

Should Nurses Eat on Own Time?

Question: We employ only graduate nurses and they work only eight hours a day. We allow them half an hour for their mealtime out of the eight hour shift. It seems to me this half hour should be on their time, not ours. I should like to know what is customary among the majority of institutions.—Sr. M.A., Tex.

ANSWER: In most hospitals special duty graduates work from 7 a.m. to 3 p.m., from 3 p.m. to 11 p.m. and from 11 p.m. to 7 a.m. The day and evening shifts have one meal on hospital time. The night shift, as a rule, does not. Some hospitals pay night nurses more than day nurses.

General staff nurses employed by the day in one well-known institution work from 7 a.m. to 3:30 p.m., allowing one half hour for the noon meal on the nurse's own time. In another equally well-known hospital the arrangement is the same as for special duty graduates. It is sometimes felt that the graduate gives some of her own time in reporting to and assisting the oncoming graduate and for this reason the half hour for the meal is allowed her.—ELIZABETH ODELL, R.N.

Half Days Off Begin at 11 a. m.

Question: When nurses are employed on a basis of eight hours daily and are allowed one whole day off weekly but decide they would rather have two half days weekly, when does the half day begin—at 11 a.m., 12:30 p.m. or at 1 p.m.?—K.R.G., Fla.

ANSWER: The old practice of the so-called half day beginning at 1 p.m. still exists in some hospitals. In reality, this allows only an additional two hours off duty as the nurse has already worked six hours. Probably in most institutions the half day begins at 11 a.m. for all groups.—ELIZABETH ODELL, R.N.

Can Nurses Replace Doctors?

Question: How far are nurses permitted to help replace doctors who have gone into service?—D.L.R., Kan.

ANSWER: The extent to which nurses are permitted to help replace doctors depends on how acute the shortage of doctors is. In some institutions selected groups of graduates have been taught to carry out certain procedures formerly carried out by doctors or interns, such as intravenous infusion. In some schools of nursing many of the lectures hitherto given by doctors are now given by nurses.—ELIZABETH ODELL, R.N.

Regulating Visiting Hours

Question: How can visiting hours be regulated? Is it advisable to lock the main entrance door during hours in which the hospital is not open to visitors?—D.P.W., Neb.

ANSWER: Theoretically, the only way to regulate visiting in the true sense of the word is to station a police officer at each of the entrances to the hospital, at the foot of each elevator and on each division. This, of course, could not and should not be done. Hospitals must constantly strive to maintain the good will and confidence of the public and the police officer technic will certainly not attain that objective. In these times, particularly, hospitals must refrain from doing or failing to do anything that would anger the public because, before this emergency is over, the public may be increasingly needed.

Again, from the negative point of view, I would suggest that extreme curtailment of visiting would require more man-hours than are warranted to control the situation.

Possibly, the best way to handle the problem is this: First, establish reasonable regulations based on a compromise between the necessity for obtaining the confidence of the patient's relatives on the one hand and the welfare of the patient on the other hand. Second, be ready to make exceptions for people who have unusual working hours, who have traveled a long distance to visit or who are visiting patients who are seriously ill. Third, sell the community on the reasons behind the visiting regulations.

The report of a special committee on uniform visiting regulations of the Chicago Hospital Council is one group's idea of what proper visiting regulations should be.

For the reasons indicated it is not wise to lock the main door to a hospital at any time.—GEORGE PECK.

HEADLINE NEWS

Penicillin Supply Low; Production Controlled by War Production Board

By EVA ADAMS CROSS
Washington Representative, The MODERN HOSPITAL

WASHINGTON, D. C.—Maj. Gen. Norman T. Kirk, Surgeon General of the Army, declared August 27 that the new penicillin drug must be carefully allotted according to the most urgent needs. The total available amount of penicillin, which has proved unusually effective in the treatment of infections that do not respond to other treatment, is extremely small, said General Kirk, and of this amount allocations are made to the Army, Navy and the committee on medical research, Office of Scientific Research and Development.

Production and allocation of the drug are controlled by the War Production Board. The total amount produced is sufficient to treat only a few hundred cases a week and the Army is allocated less than 50 per cent of that supply. The percentage made available for civilian use is distributed by Dr. Chester S. Keefer of Evans Memorial Hospital, Boston. Doctor Keefer acts for Dr. A. N. Richards, chairman of the committee on medical research. All requests to meet civilian needs are handled by these physicians.

In a W.P.B. operations circular dated August 19 it was stated that the penicillin program, sponsored by the Chemical Division, had been issued an AA-1 rating. There are 24 projects involved in the program, according to the circular, the total cost of which involves some $4,600,000.

In view of the urgency of this program as communicated to W.P.B. by the armed services, special scheduling assistance is requested from each of the industry divisions to the critical components in the program.

Textile Problems Reviewed

WASHINGTON, D. C.—The whole problem of textiles for hospitals is again under intensive study, said Everett W. Jones in an interview September 2. The Textiles Division recognizes the trouble hospitals are having in getting textiles, he added, and is right now studying the effects of Order M-328 with the idea of working out desirable amendments to the order or devising some other method which will guarantee an adequate supply of textiles for hospitals.

Quick Action Promised on Nursing School Housing to Speed Cadet Corps

WASHINGTON, D. C.—Nursing schools that will find their housing and educational facilities overcrowded by additional enrollment of student nurses can obtain prompt assistance from the federal government because of close cooperation among W.P.B., U.S.P.H.S. and F.W.A. effected by an agreement announced on September 20.

Institutions that cannot finance the entire cost of such additions are eligible to apply for assistance under the Lanham Act if they are participating in the cadet nurse corps program.

This arrangement has been made possible by the cooperation of Maj. Gen. Philip B. Fleming, administrator of F.W.A., with Dr. Thomas Parran, surgeon general of the U.S.P.H.S.

According to Doctor Parran, "the problem now is to increase educational facilities if we are not to lose many greatly needed candidates for the nursing profession."

Maury Maverick has promised to have all projects cleared through the War Production Board as expeditiously as possible, He emphasizes, however, that new construction must be avoided wherever possible by leasing or purchasing an existing building for alteration or rehabilitation. When new construction is absolutely necessary, it must be of the simplest type possible.

Institutions applying for financial aid under the Lanham Act should make a preliminary request to the regional office of the Federal Works Agency having jurisdiction in the state. Applicants should:

1. Give the name and address of the school of nursing and institutions, if any, to which affiliated students are assigned.
2. State whether or not application has been made to the U. S. Public Health Service for participation in the cadet nurse program.
3. Give the number of additional accommodations that will be required.

The regional F.W.A. director will notify the U.S.P.H.S. that the preliminary request has been received, a field survey will be made, and the applicant will be instructed in F.W.A. procedure for formal applications.

(*Continued on page* 140)

Photo from U. S. Public Health Service

ACT TO SPEED UP NURSE HOUSING: Dr. Thomas Parran, surgeon general, U.S.P.H.S.; Henry Sullivan, assistant regional director, F.W.A.; Lucile Petry, director of the division of nurse education, and Lt. Comdr. Vane Hoge, M.D., surgeon-in-charge of hospital facilities, U.S.P.H.S.

Use of Home-Canned Foods by Hospitals Encouraged by Recent O.P.A. Decisions

WASHINGTON, D. C.—The recent appointment of Kris P. Bemis as associate director, food rationing division, and chief of the institutional users branch of O.P.A. with responsibility for the food allotments for hospitals, filled a vacancy that was left when Leighton Arrowsmith marched into Washington and marched out again almost before the news of his appointment could be announced.

Mr. Bemis has been with O.P.A. in Philadelphia since approximately the beginning of food rationing as the district food rationing officer. Before that he was a marketing specialist of the U. S. Department of Agriculture.

Since his appointment, changes in rationing affecting hospitals have been frequent. On August 17 institutional users were required to report the number of persons served during the ration period for whom they received supplemental allotments. This report is required when the user applies for his allotments for the second allotment period following the one for which he receives the supplemental allotment. This reflects more accurately the needs upon which the supplemental allotments were based. If the supplemental allotment was larger than needed, the difference will be deducted from the allotment applied for.

On September 2 point changes on 21 food items were 13 up and eight down. In addition, point values of four points per pound were set for dried prunes, dried raisins and currants.

On September 5 it was announced that charitable institutions could use unlimited amounts of processed foods produced from fruits and vegetables that ordinarily would not be distributed commercially. These include: fruits and vegetables which an institution grew and processed for its own use; foods that the institution processed from gifts of fruits and vegetables that would not ordinarily have been marketed commercially, including local surpluses from W.F.A., and gifts of processed foods produced from noncommercial supplies.

O.P.A. will charge the institutions for the amount of these foods at their current point value but in no case will it charge an institution more for any item than 10 per cent of the total points it received in its last regular and supplementary allotments. The amendment applies to government-owned hospitals.

New hospitals can establish a base month for rationing purposes as the most recent calendar month of operations between Jan. 1, 1942, and Feb. 28, 1943, or thirty days preceding the application for second allotments.

Typewriters, Office and Laundry Equipment Now Being Manufactured

WASHINGTON, D. C.—Calling attention to renewed production of four types of products, Everett W. Jones stated in an interview September 2 that limited production schedules are in progress for typewriters, domestic laundry equipment, commercial laundry equipment and office equipment.

Production, however, is limited to military and other requirements essential to the war production program. The authorization of the W.P.B. was not to be interpreted, he pointed out, as a general relaxation of existing restrictions on these particular items.

The four orders affected by these amendments are: L-54-c, office equipment; L-91, commercial laundry equipment; L-54-a, typewriters, and L-6-c, domestic laundry equipment. Other changes made by W.P.B.'s action include an authorization in Order L-54-c for purchase of time stamping machines, time recording machines and collateral equipment that now corresponds to an A-1-a rating rather than an A-7 rating as was previously the case. When specifically authorized, production is permitted in L-91 of parts for rebuilding, reconditioning and repairing specified types of laundry and cleaning equipment. Also, the appeals clause in the order was rewritten.

Care for Servicemen's Wives Okayed in All but Four States

WASHINGTON, D. C.—All but four states have received approval for their plans for the care of wives and infants of men in the armed forces, according to an announcement from the Children's Bureau of September 17. The states not yet included are Louisiana, Texas, North Dakota and Colorado. Pennsylvania's plan was approved on the 17th.

The birthrate among wives of enlisted men is exceeding all expectations and Congressman Clarence Cannon, chairman of the house appropriations committee, has introduced a bill to make a deficiency appropriation of $18,600,000 to maintain the existing program through the rest of this fiscal year.

Additional Facilities for Training Nurses Are Urgently Needed

By EVA ADAMS CROSS
Washington Representative, The MODERN HOSPITAL

WASHINGTON, D. C.—The U. S. Cadet Nurse Corps is attracting large numbers of candidates throughout the country, said Lucile Petry, director of the Division of Nurse Education, U. S. Public Health Service, in an interview September 9. But redoubled effort is necessary to overcome the two bottlenecks of nurse shortage and lack of facilities for nurse training.

Extension of *existing* training facilities is the first effective immediate step to be taken, insisted Miss Petry. The three most frequent limitations in schools of nursing are those of clinical facilities, housing facilities and teaching personnel.

By the annexation of more clinical facilities, nursing education and good nursing care may be extended far beyond present limitations. Further expansion in almost all schools of nursing is prevented by the shortage of one clinical service.

For example, said Miss Petry, a school with surgical, pediatric and obstetric facilities might now admit 75 students annually if medical service were added. But because of limited medical service, it has been forced to hold the enrollment to 50 students a year.

An affiliation in medicine would allow for peak admissions and would help to meet nursing needs for the added medical patients. If every school in the nation were to add a psychiatric affiliation or any other three month affiliation, and at the same time keep its residence as filled as it is now, admissions would increase by 10 per cent this year and many more patients would receive adequate nursing care.

Housing facilities are expanded when affiliations are established. Students may be permitted to reside at home or with relatives or at other approved homes. Senior cadets and graduates may "live out." Procurement of added housing facilities should be investigated. Temporary construction is possible through Federal Works Agency with Lanham Act funds.

To help meet the shortage of teaching personnel, instructors should be allowed to confine their activities to teaching. Married nurses and qualified nonnurse instructors should be brought into service. Central teaching plans and sharing of faculty members are plans worth trying, while qualified senior cadet nurses may act as assistants to nursing arts and clinical instructors. Greater economy and effectiveness will result from better coordination of instructional programs.

LOOKING FORWARD

An Outstanding Year

THE Buffalo convention which just closed brought to a happy conclusion the most active and significant year in the history of the American Hospital Association. Events have crowded upon each other with almost breath-taking rapidity. It is not possible to summarize all of them but a brief review will serve to give a setting to the convention portfolio that appears elsewhere in this issue.

Heading the list of accomplishments was the increase in the dues of institutional and personal members. While this increase is substantial when expressed in percentage terms, it amounts to only $225 per hospital at a maximum in actual cash. The benefits to hospitals should, in a year or two, far outweigh the increased cost.

Although this change aroused considerable controversy, the final vote in the house of delegates showed a 5 to 1 favorable majority. This probably reflects the sentiment that will be found among the 3000 institutional members when they have learned all the facts given out at Buffalo.

A second important accomplishment was the announcement that financing had been practically completed for the National Commission on Hospital Care. This is the commission that was authorized last year by the house of delegates. A grant of $35,000 was made by the Commonwealth Fund and other foundations have indicated that they probably will make grants to complete the budget.

A third significant accomplishment is an arrangement with the U. S. Public Health Service for taking chest x-ray plates of all cadet nurses in an attempt to eradicate tuberculosis in this group. One speaker at the convention reported that student nurses generally had about five times as many breakdowns from tuberculosis as women college students. The A.H.A. is to manage and direct this program which will probably involve a cost running into six figures. Funds are to be provided by the U.S.P.H.S.

A new council on international hospital relations, similar in membership, organization and responsibilities to the other six councils, was authorized by the trustees. Much progress was made toward the coordination of the work of the American College of Hospital Administrators with that of the A.H.A., with each organization retaining its identity.

Other accomplishments during the past year to which President James A. Hamilton can look with great personal pride are the selection of a new executive secretary, the vast improvement in format and contents of *Hospitals,* the appointment of a new librarian for the Bacon Library, the establishment of the Wartime Service Bureau, the exceptionally vigorous work of the Blue Cross approval committee, the establishment of the U. S. Cadet Nurse Corps and the welding of a much closer relationship between hospitals and nurses. Credit for many of these achievements should be given in generous measure to Mr. Hamilton, who at great personal sacrifice has personally directed a large part of the work.

Hospitals Approve Cadet Corps

AS REPORTED in detail elsewhere in this issue, the United States Public Health Service had by September 1 received applications from more than 500 accredited schools of nursing to participate in the cadet nurse corps program under the Bolton Act. Sixty-seven of these applications had been approved on that date and many others were approved during the ensuing month.

Some fear had been expressed by leaders in the hospital field that the significant changes in nursing education foreshadowed by the new act would cause hospital administrators to hesitate in applying for its benefits. Apparently that is not the situation. Many of the outstanding hospitals of the United States have studied the whole situation carefully; have had an opportunity to obtain answers to their questions at first hand from Surgeon General Thomas Parran and from Lucile Petry, director of the new U.S.P.H.S. division of nurse education, and have decided to cooperate in the program.

Those hospitals that do not at present have nursing schools may be considering seriously the possibility of starting or reviving schools. Fortunately, expert assistance is readily available.

First, hospitals should consult the "Essentials of a Good School of Nursing," published by the National League of Nursing Education. Second, they can check with the local or state nursing council for war service to determine whether there will be enough qualified applicants to form suitable classes. The most difficult problem may be the enlistment of an acceptable faculty,

unless present staff members are competent to undertake this function.

Nursing is on the march. Everyone who has studied the portfolio on "Nursing—War and Postwar," which appeared in this magazine last month, not only is conscious of that fact but has some inkling of the objectives toward which it is marching.

Although some nurses complain of the attitudes of some hospital administrators, cooperation between nursing and hospital groups has never been better than it is today. Over the long pull and in spite of a few temporary disagreements, hospitals will assist nurses in reaching the improved position to which they aspire.

One Third More Health Service

SOME idea of the possible expansion of American production in the postwar period is given in a recent brochure by the Committee on Economic Development headed by Paul G. Hoffman of the Studebaker Company. The experts working for the committee have estimated that in 1946, if industry has been reconverted and if 96.5 per cent of the people seeking employment actually hold productive jobs, the total gross national production (including goods, services and governmental activities) will be $142,000,000,000 as compared with $97,000,000,000 in 1940.

For the services involved in nongovernmental medical care and death expenses (not including the goods utilized) the committee estimates that the nation will spend $3,686,000,000 in place of $2,766,000,000. Both figures are given in terms of the 1940 general price level.

This represents an increase of one third in expenditures for medical care, apart from the large increases that will be made for the care of veterans of this war and other governmental expenditures. While this is not as large an increase as that predicted for automobiles or for radios, it is, nevertheless, sufficiently large to merit careful thought on the part of hospital administrators.

Perhaps the way in which it may come about was hinted by Dr. James E. Paullin, new president of the American Medical Association. In his inaugural address he said that "the trend of medical practice inclines toward the establishment of the hospital and the medical center as the source for the distribution of medical care. The present emergency has accentuated the needs for such an arrangement."

Recently, the American College of Hospital Administrators found that a considerable number of its fellows and members are thinking seriously of the hospital as a medical service center for the community. Such thoughts should not merely rattle around loosely in the administrator's brain. The time is here when the administrator, the board of trustees, the medical staff and the architect should begin joint conferences looking toward embodying these broad ideas in actual service to the people. Two years is not too much time to spend in planning a new hospital or a major addition to an existing building.

Voluntary Giving

WHEN the 17 agencies that have been federated as the National War Fund set out this fall to raise $125,000,000 from the American people they embark on the largest charity drive ever launched. The funds are to provide for the U.S.O. and other services to our armed forces, for relief in Russia, China, Britain and nine occupied countries, for aid to refugees and for contingencies that will arise because of military operations.

In many localities the war fund drive will be combined with the regular drive for the support of the local community chest. In certain areas the campaigns are being extensively broadened.

Voluntary hospitals should follow the course of the campaigns this fall with close attention. From the experience gained in such drives during World War I were developed the technics that have raised much of the funds for building and expanding our present voluntary hospitals and other social agencies. The drives undertaken during this present war may point the way to new and better technics that will give the voluntary hospital a chance to broaden and increase its base of financial support.

"Teaching" Material

THE growth of prepayment plans, whether under voluntary or governmental auspices, may be expected to continue rapidly. As they expand there are fewer and fewer people who are forced to rely upon charity for their hospital care.

One result of this will be that the "teaching" patients formerly found in the free wards of voluntary and governmental hospitals will no longer be there. They will have moved to pay wards or to semiprivate or, even, private accommodations. Will this hamper medical education?

It need not, if the advice of the Commission on Graduate Medical Education is heeded. In its final report in 1940 the commission made the following comment:

"The supposition on the part of some educators that only those patients occupying free beds can be used as teaching material is not entirely sound. Some institutions have made semiprivate and private patients available for teaching purposes without lowering the quality of teaching opportunities. By so doing they have actually increased the quality and character of patient care."

General view of U. S. Naval Mobile Base Hospital No. 1, Bermuda. The various field laboratories and buildings for operating rooms are marked with a red cross. All pictures are official U.S. Navy photographs.

Where the Navy Goes

There Go the Mobile Hospitals

CAPT. LUCIUS W. JOHNSON, (M.C.)
U .S. Navy

EVEN in times of peace, a well-balanced Navy must have one foot firmly planted on the beach. Bases on shore are necessary for training recruits, for repairs, for assembling supplies and for many other purposes. In time of war, they must be greatly increased in number and advance bases in strategic areas must be rapidly developed.

Never before has our Navy had so many shore bases as during the present war. They may be likened to stepping stones. A force is sent out to seize or occupy an island or area well in advance of the main force. This area is developed until a larger force can be established there, and then it serves as a base from which expeditions can be sent forward to claim other areas.

These advance bases are employed to assemble men and materials, to provide repairs and as a place for unloading cargo ships. Each one of them requires a hospital of size and equipment commensurate with the number of men at the base and the type of work they are doing.

One of the most interesting developments in the entire medical scene of action during recent times has been the organization and building of these advance-base hospitals. The various steps of their development can be traced in the back numbers of The Modern Hospital. One of the earliest was set up in Queenstown, Ireland, in 1918.[1] Its scion, of 22 years later, might be described as the Navy's first experiment in hospital mobility.[2] The most important advances during the current war must remain, for the present, shrouded behind the curtain of censorship, but enough can be said to indicate some important general trends.

Naval Mobile Base Hospital No. 1, familiarly known as Mob. 1, was the experimental unit, sent out as a guinea pig to determine by trial and error the best type of housing, equipment and administration for hospitals at advance bases. Our experiment developed a thousand gremlins, griggetts, gobfins and other jinxes that took a grim humor in complicating our work and increasing our problems. These have been almost eliminated in the later hospitals.

Note: The ideas and opinions here expressed are the individual views of the author and are not to be regarded as the official policy of any government department.

[1]Johnson, L. W., and Miller, R. V., A Navy Base Hospital Overseas, Mod. Hosp. **13**:231 (April) 1919.

[2]Johnson, L. W., Hospitals at the Front, Mod. Hosp. **58**:46 (January) 1942.

Speed is essential in constructing a base hospital and officers and men worked together to establish this unit in Auckland, New Zealand. Here is the hospital anesthetist helping to make an athletic field into a hospital.

An important reason for these improvements is the fact that one of the Navy's most forceful, far-seeing and intelligent officers, Rear Admiral K. C. Melhorn, (M.C.) U.S.N., was ordered in command of the Naval Medical Supply Depot in Brooklyn, N. Y. This depot has the function of procuring and distributing all the special articles required by the activities of the medical department of the Navy.

Through Admiral Melhorn's vigorous action, practically all the deficiencies in procuring, packing and transporting hospital materials have been corrected in spite of the limitations of the market. There now is a steady flow of necessary supplies and equipment to even the most remote hospitals.

Mobile Base Hospital No. 2 was later organized under the command of Capt. John H. Chambers, (M.C.) U.S.N., who had played an important part in developing the first one. This hospital had been sent to Hawaii late in 1941 and its buildings were in course of erection near Pearl Harbor when the Jap attack occurred. In spite of its incompleteness, the staff commenced at once to receive and care for patients.

The hospital staff functioned so admirably that the hospital received a citation for distinguished service, awarded by Admiral C. W. Nimitz, commander-in-chief of the Pacific Fleet. Other mobile base hospitals have been assembled and rushed to places that you read about in the headlines and also to places that are exceedingly hush-hush. Their number is now approaching a score.

The Navy's advance-base hospitals may be regarded as mobile enough for one move, but after they are once set up they put down roots and become quite firmly established. The highest degree of mobility is found in some of the Army's recently created hospitals, which have everything on wheels and tents for housing. Such extreme mobility is not usually necessary for the Navy since that need is filled by the use of hospital ships and ambulance ships. Such ships have recently been described in The MODERN HOSPITAL and there is little more that can be told at this time.[3] Their number is greatly increased and they are doing most noble work in caring for and transporting patients in many war areas. One hospital ship, *U.S.S. Solace,* has already been cited for distinguished service.

The far-flung net of advance-base hospitals touches every climate from that of Iceland to the humid heat of regions under the equator. Some have moved into primitive lands that previously were little known to the white man. Others are located near large cities, with all the niceties of civilization. Many new and intricate problems have been imposed on the doctors and on the hospitals by the occupation of bases on distant shores. Problems of racial differences, food, religion, construction materials, climate, terrain and supplies have been numerous.

The plans for the hospital to which I am attached, and it is of a more permanent nature than the average, were carefully prepared and blueprinted before we left the United States, using all the information that we could accumulate in advance, but not knowing where we were to go. After arriving and studying the local conditions, the blueprints were discarded, we went back to zero and started over again to adjust the plan to the new knowledge of requirements.

Then I took a trip to see what had been done at other advance-base hospitals in the area. I gathered so many new and excellent ideas that I scrapped the plans a second time. When they were drawn anew I submitted them to the staff for criticisms and suggestions. It was like throwing one's baby to the wolves. The plans were completely remodeled for the fourth time, and the final result has been very satisfactory. In this war, efficiency has often to be sacrificed to other considerations, such as protection, camouflage and dispersion.

The speed with which these advance-base hospitals grow reminds me of the desert flowers in the Mojave area. Visit this wasteland one day and you will see only a limitless expanse of sand and rocks. A few days later, countless green spikes show their tiny points above the surface. At the end of a week there are square miles, solidly carpeted with the gorgeous pastel tints of the desert verbena, interspersed with the yellow, red and blue of other flowers.

[3] Johnson, L. W., All for the Life of a Sailor, Mod. Hosp. **26**:42 (June) 1936. Jensen, H. C., and Stedman, H. E., Behind the Scenes on a Hospital Ship, Mod. Hosp. **61**:63 (Aug.) 1943

So it is with these hospitals—one day, a pile of bales, boxes and crates on the dock, or on the beach above high tide; a few days later, a busy hospital. But nobody who has not gone through the mill can imagine the enormous amount of hard work, sweat and determination that has gone into that transformation.

Many organizations that are not essentially combat units are sent close to the fighting front for special duties. such as engineering, sanitation and construction. These may operate indefinitely at a considerable distance from any fixed base. Therefore, each one requires its own medical and hospital equipment. Outfits for such units have been standardized according to the size of the force, its special work and the area in which it operates.

A message requesting such an outfit brings in response the standard supplies and equipment, packed with a view to the means of transportation and the climate to which they will be exposed. This streamlining of hospital facilities results in a great saving of time required to give good medical and surgical care. It is undoubtedly an important factor in the low death rate.

Success or failure of these hospitals depends in large measure on the same factors as in hospitals at home, and the most important of these are the ability and the morale of the men who run them. Our enlisted men are a particularly interesting study in this respect. Their education varies from that of the boy who never got beyond the sixth grade to one who has taken his M.Sc. in entomology since joining our outfit.

Only yesterday these men were artists, bankers, bakers, carpenters, teachers, embalmers, salesmen, truck drivers, playwrights, oil-well drillers or dancing instructors, and a host of other callings was represented. Today they are building the hospital and working as loggers, ditch diggers, steel erectors, crane operators and general roustabouts.

Tomorrow, when the hospital is completed, they will be technicians in the x-ray, dental, surgical and other clinics, clerical workers and storekeepers and as excellent nurses as a sick or wounded man could wish to have.

The competence and versatility of the men of the hospital corps are sources of constant gratification. Their sense of humor never fails and they find more fun in hardships and mishaps than they do in comforts and luxuries.

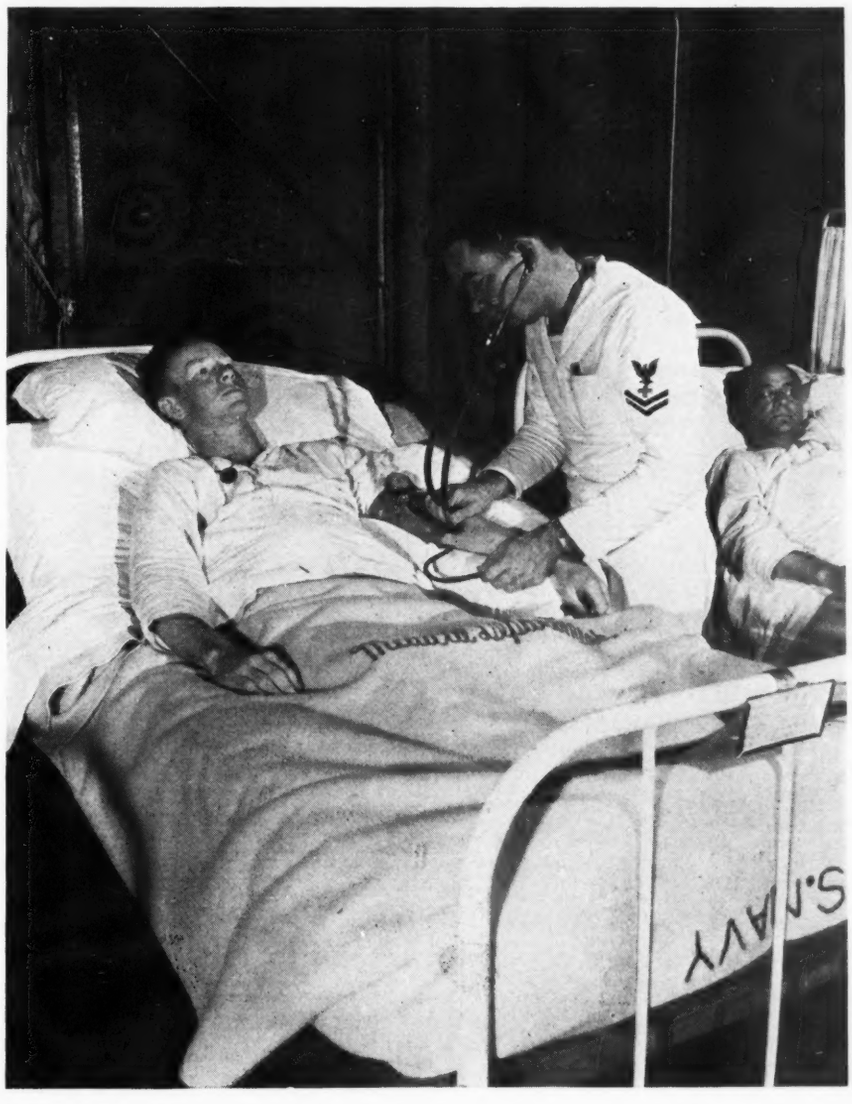
Recently, I saw a white woman for the first time in three months. She was an Army nurse. The hospitals at the most advanced bases are hardly suitable places for women. The primitive toilet facilities are out in the open and the men wear clothing only to protect themselves from mosquitoes or to have their pictures taken. There is a natural tendency of men bereft of women to discard more and more of their clothing as time goes on.

When mud and rain are universally and continuously present, clothes become a genuine handicap and the less one wears the more comfortable he is.

A Frenchman, discussing the advisability of women nurses on hospital ships, stated that the nurses selected for such duty should be "very strong, very competent and of very advanced age." His statement puts into a few words all the complications of having women nurses at advance-base hospitals.

The doctors, who are nearly all reserves, have given up their practices, their homes and all their profitable civilian connections to do what they can to help win the war. Once they have burned their bridges behind them, they become thoroughly interested in every phase of this work. They revert cheerfully to most primitive conditions of living and working and seem thoroughly to enjoy the game.

It is both interesting and profitable to rediscover, from time to time, that life can be reduced to extremely sim-



Behind this scene lies a great organization maintained in a mobile condition but complete in its facilities. There must be quarters for enlisted men and officers, mess halls, laboratory, pharmacy and recreation areas.

This laboratory, with it staff of trained enlisted technicians, is indicative of the completeness of the mobile hospital units.

ple terms and still be highly enjoyable. Millions of men in the armed services are making this discovery and enjoying it, even though we are not always conscious of it. In much the same way, a great deal can be done in giving medical service with extremely simple equipment.

Our many small wars in Central America and the Caribbean republics in the early years of this century taught the naval medical officer of those days to go out into the bosque with a pocket case and a packet of pills and do a great deal for both the Marines and the natives. That ability, of which we felt so proud in my younger days, is now being relearned by thousands of medical officers of both the Army and the Navy.

Some of these advance-base hospitals are designed to provide care for special types of cases. As in previous wars, there have been surprises for the medical department, as for other branches. Percentages of wounds and the various diseases have not followed the expected rules. For the present, mention of the special diseases in certain areas is tabu and it is not profitable to arouse the suspicion of the Argus-eyed censor by alluding to them.

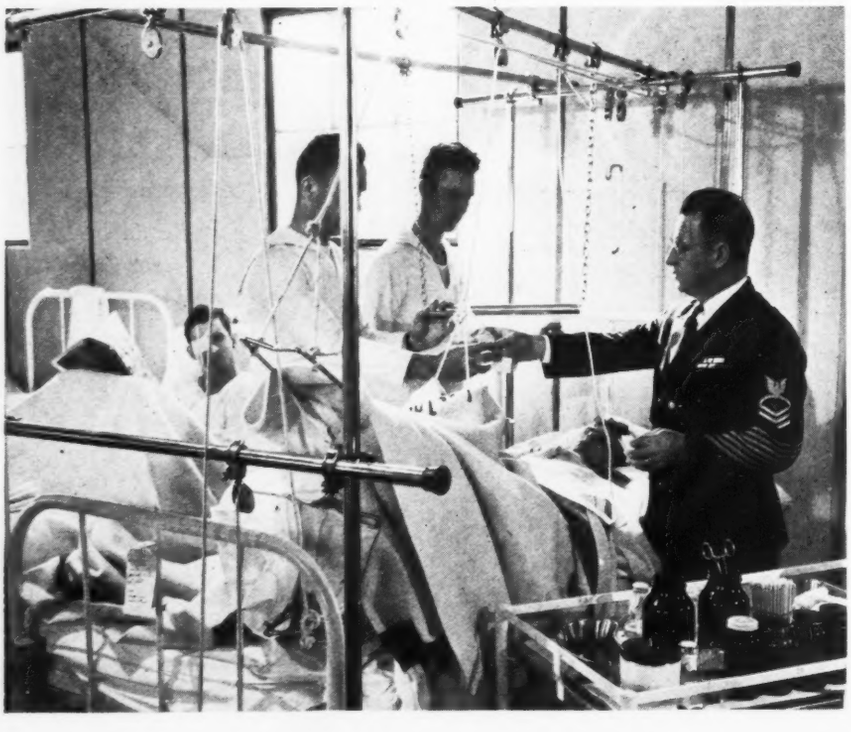
The furniture provided is simple, adequate and easily transported. The men vie with one another in making clever and ingenious pieces of furniture for ward use and for their own convenience. Each tries to acquire a hammer, saw and nails for his traveling outfit. There are handmade pieces of every conceivable use and design.

The commissary department must get along without many of the conveniences that help to make the work easier in fixed hospitals. The dreaded K.P. rears its ugly head once more. Most of the food is dried or canned and few fresh articles are available from local sources. The staff turns out an excellent diet with the most primitive means.

Housing for an advance-base hospital should be easily transported, quickly erected and durable enough to last for a minimum of two years. Tentage is recognized as the most expensive shelter for troops. Its first cost is not so high but its life is short when exposed to the weather. It is easily transported and can be quickly set up but it has several disadvantages that reduce its value for hospital purposes.

Several types of prefabricated buildings, some of wood and some of metal, are being employed and they completely fill the needs of advance-base hospitals.

This is a development that should be carefully watched by leaders of the hospital world, for many ingenious ideas have been worked out and are now in mass production. The special structures for wards, clinics, operating suites, kitchens, laboratories and other departments are models of convenience. They offer good hospital facilities quickly and at low cost. One can imagine many emergencies in civil life after the war that can be admirably served by these prefabricated hospitals.



The most modern equipment is used in this unit in Auckland, which was in operation a month after construction was started.

CONVENTION DIGEST

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HOSPITAL delegates who reached Buffalo on Friday night found a rainstorm that flooded streets from curb to curb. From then on, however, the weather was clear and fine.

Much the same situation was encountered in the intellectual fare of the meeting. After the stormy session on the increase in dues, the barometer rose and skies were sunny.

The attendance was somewhat below previous years, fortunately for the hotels and other living accommodations. Even so, the Statler reported that it refused 600 or more reservations. Delegates filled all of the other hotels in Buffalo and many of those in Niagara Falls.

Exhibitors, although almost without items to show, were happy that the program was arranged so that hospital people had time to visit the exhibit. Perhaps the abominable acoustics in most of the meeting halls accounted for better attendance at the exhibits.

In general, the footsore audience seemed to appreciate the fact that the afternoons were cleared for the most important sessions. All sectional meetings were held in the mornings. Those few who didn't care for the afternoon program had time for exhibits or Niagara Falls or hunting up eating places that *didn't* serve chicken.

Last year the delegates were worried and cross. This year they were worried and cheerful. No matter how difficult a problem faced their hospitals at home, someone else was sure to be there who was in a worse state. The administrator of a state mental hospital who has lost 95 per cent of his personnel didn't come. But he was talked about.

The shock of the increased association dues pretty well wore off during the week. Those who predicted that half the hospitals would drop their membership had reduced that mournful prediction to 20 or 10 per cent. Others predicted little or no loss. Many people seemed to be satisfied that the association had a program that really required the money, that the officers could be trusted to spend it wisely and that the hospitals would benefit accordingly.

It was made abundantly clear that no individual was to get a salary of $25,000 or $30,000 from the association.

The publicity for the convention, carried on in the newspapers and over the radio, was outstanding and went without serious hitch. It was far different from the madhouse atmosphere in the publicity office at St. Louis, where conflicts of authority hampered the program. So many evidences of public confidence in the ability of the A.H.A. to do worth-while jobs in the public interest occurred during the week that the members took a renewed pride in the maturity of their organization. Among these were President Hamilton's announcement that financing was assured for the National Commission on Hospital Service, the announcement that the A.H.A. would administer for the U.S.P.H.S. a large tuberculosis case finding program among students in the U. S. Cadet Nurse Corps and the frequency with which federal officials turned to the association for counsel and advice.

The appointment of Everett W. Jones to The MODERN HOSPITAL staff aroused much congratulatory comment. In his president's report, Mr. Hamilton said that "I can't say too much in praise of Ev. Jones."

The joint committee of the A.H.A. and the A.C.H.A. had some stormy sessions as long as there was the proposal for the former to take over the latter. When that was turned down, a harmonious relationship was established that looks to better cooperation in the future.

The A.C.H.A. will, hereafter, conduct the Chicago institute for hospital administrators. The A.H.A. may expand its institutes for department heads, adding one for personnel managers to the existing institutes for accountants and

purchasing agents. The A.C.H.A. announced two gifts of $1000 each, one from The Modern Hospital Publishing Company and another from an anonymous donor.

House of Delegates

It was not an easy matter to decide the question of increasing the A.H.A. dues. Some members came to the house of delegates session to fight the proposal made jointly by the committee on association resources, the committee on constitution and by-laws and the board of trustees with an alternative that would provide dues at a level only 50 per cent as high as the officially endorsed proposal.

This amendment was offered by Harold T. Prentzel of Friends Hospital, Philadelphia. Support for his position was voiced by some of the delegates from Ohio, New York and Nebraska but it was apparent in the voting that the various state delegations did not vote as units.

The Canadian hospitals, which now receive a 25 per cent discount on their dues, probably will have some further arrangement made that will be mutually satisfactory, President Hamilton stated in response to a question from Dr. A. K. Haywood. This is necessary because the Canadian hospitals also support the Canadian Hospital Council and because they do not receive direct benefit from the national legislative activities of the A.H.A.

Extensive reports on the A.H.A.'s present financial situation were presented by the treasurer and the executive secretary. Then at the opening of the second session of the house on Tuesday evening, President Hamilton set the stage with a long and frank statement of the whole financial situation as he saw it. He answered many of the honest criticisms as well as the unpleasant rumors that had circulated throughout the headquarters hotel.

A strong speech by Dr. Robert H. Bishop, who had just been installed as president of the A.C.H.A., and warm support by Stuart Hummel, Arden Hardgrove, Everett W. Jones, William P. Butler, W. E. Arnold, Jessie Turnbull, Robert Jolly, Frank Walter, Dr. Frazier D. Mooney, F. Stanley Howe, Dr. Herbert Wagner, C. J. Hassenauer and Horace Turner served to defeat the Prentzel motion on a vote of 62 to 12. The amendment was later passed by voice vote of the assembly.

A motion to direct the A.H.A. officers to attempt to obtain extension to proprietary hospitals of Order 26 of the War Labor Board was defeated when it was explained that three previous attempts had been made and that further effort along this line might result in repeal of the order.

The A.H.A. will collect both state and national dues for affiliating states when requested and will continue to return 10 per cent of the dues collected to the affiliating state association.

The proposal to limit the terms of trustees and members of the councils and of the Hospital Service Plan Commission was voted down strongly by the house of delegates but in the assembly it came within an inch of passing. The assembly vote on this proposal was 130 in favor and 72 against. Since a two thirds affirmative vote is required to amend the constitution and by-laws, the amendment failed by four votes. Had it passed, the action of the assembly would have overruled the action of the house of delegates.

The nominating committee and the new president are put in a rather embarrassing position by the fact that the amendment was defeated and yet apparently represents the majority view.

JAMES A. HAMILTON

The delegates voted also to give power to the council on administrative practice to keep control and direction of the National Commission on Hospital Service, if in the judgment of the council this seems desirable.

In reply to the American Medical Association's request that the A.H.A. disapprove the proposed uniform national Blue Cross contract, the house voted that the objective is to encourage the best possible hospital service and that the uniform contract will contribute to this end. The delegates voted to appoint a committee to confer with officers of the A.M.A.

In his report to the house on the work of the Blue Cross approval committee, Dr. R. H. Bishop said the program needs to be more clearly defined as regards approval and promotion of plans.

Manpower

Official Washington came to Buffalo trim in the uniforms of many services to tell the hospitals what further sacrifices they must make and what plans are brewing to make these sacrifices less crippling to the care that will be given civilian patients during the war.

All eyes, including those of many cameras, followed the graceful movements of Lucile Petry, smartly attired in the U. S. Cadet Nurse Corps' gray uniform with the red cross bars on the shoulder, and her appearance and personality made the C.N.C. the talk of the convention.

Cmdr. Max E. Lapham of Procurement and Assignment Service was there with his 9-9-9 plan for internship and residencies and Surgeon General Norman T. Kirk gave hospitals thanks for the 13,202 members of the Medical Administrative Corps and some of the 59,000 technicians now in the Army; at the same time he solicited another 600 physicians and 1000 dietitians.

L. Louise Baker of Procurement and Assignment came to ask from the largest employers of nursepower, the hospitals, close cooperation with the local committees that are now classifying all nurses as to their availability for military service or their essentiality for civilian service. Hospitals have a larger percentage of nurses eligible for military service than have private duty, public health and industry so they must use persuasive means to get them into military service or essential nursing jobs.

The armed services have a priority on nurses and interns, the hospitals were bluntly told, and P. and A. proposes to see that the remaining personnel is equitably divided on the basis of actual need.

In hospitals the director of nursing, assistant director, instructors and general staff nurses should be classified as "essential" but no others. Those nurses eligible for military service may be classified as essential until they can be replaced. Each state now has a quota for 1943 for the armed services and 11 states have already met this quota.

The hunt for hidden nurses is on and Commander Lapham, in asking the assistance of the women's auxiliary of the American Medical Association in this program, hopes thus to dislodge for duty in hospitals and in the armed services not only R.N.'s in the doctors' offices but many of the R.N.'s who are now wives of M.D.'s.

The new 9-9-9 plan is P. and A.'s answer to the needs of the armed services for more doctors and to an equitable distribution of interns and residents among civilian hospitals. The Army and Navy are cooperating not only to change

the internship to nine months but to defer about one third of the interns for a nine months' residency and later to defer one half of these for a nine months' senior residency.

Hospitals will get none of these interns until they have made every effort to get as many young graduates physically disqualified for military service as they can procure. The 9-9-9 men will then be distributed on a quota basis.

Administrators heard from Jean Henderson of U.S.P.H.S. of their part in recruiting nurses for that "perfect package," the cadet nurse corps. The super-sales message that each of the 6500 accredited hospitals is expected to carry to young women is that C.N.C. combines patriotic war-time service and a promising postwar future.

"After the war I'd rather be a Lady With a Lamp than a Lady With a Blow Torch" is one cadet nurse's slogan.

Miss Henderson broke the news that the campaign won't end if 65,000 nurses are recruited by the end of the fiscal year. That quota was set merely because it was estimated that training schools could not handle more students. A strenuous effort will be made to expand training facilities since the acute need is for more than 100,000 new student nurses.

Postwar Planning

We must plan to enable every individual to attain maximum physical and mental development and to have an equal opportunity for health within the limits of his inherited capacity.

This was the ringing challenge to postwar planners in the health field thrown out by Dr. Thomas Parran, surgeon general of the United States Public Health Service.

Two basic aspects of freedom from want are food and health, the distinguished S.G. declared.

Disease prevention and control will be more of an international problem than ever before, he said, pointing to the development of air transport and other speedy communications.

Doctor Parran's philosophy is that public health work and actual medical care are merely two facets of the same problem, a point of view that has done much to break down the arbitrary walls that used to circumscribe the activities of the U.S.P.H.S.

While calling vigorously for a wide extension of the insurance principle for hospital and medical care, Doctor Parran carefully left the way open for voluntary effort. But to serve less than 10 per cent of the population is not enough, he declared with considerable warmth.

He urged hospitals to become, in fact, community health centers with groups

EDMUND FITZGERALD

of physicians working together around a well-organized hospital. Without mentioning the American Medical Association by name, Doctor Parran deplored that association's negative program.

The large audience, which comfortably filled cavernous Goldwater Hall, gave Doctor Parran hearty applause.

He was followed by Brig. Gen. Frank T. Hines, administrator of veterans' affairs. General Hines brought the audience up to date on construction of veterans' facilities, as now planned, which will give this administration approximately 100,000 hospital beds by the end of next year.

The meat of his paper, so far as non-federal hospitals are concerned, he saved till last. This dealt with the use of civilian hospitals by the Veterans Administration.

His statement was vague—necessarily so. A specific answer depends upon the number of casualties and the proportion to be turned over to the Veterans Administration. If possible, they must be accommodated in federally owned facilities. If this is not feasible, male patients can in emergencies be sent to civilian hospitals.

For female veterans — and General Hines anticipated that there will be several hundred thousand potential patients in this group—a wider use of civilian hospitals is expected.

However, General Hines has been unable to negotiate contracts with civilian hospitals "to the number and at the rates desired." He did not specify what these rates are. The shortage of personnel and equipment was given as the reason for this situation.

After Edmund Fitzgerald had finished speaking, Joseph Norby became one of the most widely envied men in the hospital field. For Mr. Fitzgerald is president of the board of Columbia Hospital, Milwaukee, which Mr. Norby administers.

In simple direct language, Mr. Fitzgerald outlined his concept of the place of the voluntary hospital in the postwar world. There was no difficulty in following his logic. It is that the voluntary hospital that does a good job for its community will grow and prosper while the one that, through timidity or lack of foresight and intelligence, falls down on its job will face an uncertain and dark future.

Each hospital should lay out its program of development in a simple one page statement. Mr. Fitzgerald then suggested such a statement and his listeners suspected that they were listening to the program of the Columbia Hospital. In brief, it covered the following:

This hospital is organized to function as a public health agency of the community. Hence, it should provide equipment and facilities for conducting the hospital work on a high level. Because quality is paramount, the medical staff should be appointed by the trustees only on recommendation of the executive committee of the staff. All needed adjunct services should be provided. Educational progress is obligatory. The physical plant should be kept in the best possible repair. The hospital should assume responsibility for a larger percentage of the people in its territory, increasing its capacity as needed.

President Hamilton announced with pardonable pride that funds had been practically assured to finance the work of the National Commission on Hospital Service. One grant, $35,000 from the Commonwealth Fund, had already been formally made and additional grants will probably bring the budget up to the $100,000 or so needed.

Hope that this commission will present the pattern that will guide American hospitals through the pitfalls of the reconstruction period was expressed by Frank J. Walter, newly installed president.

Outlining the plans of the association for the coming year he laid stress on the following three great purposes: (1) the meeting of current manpower and supply problems; (2) a judicious and far-sighted planning of the hospital's place in the postwar democracy, and (3) the greater expansion of our democratic and voluntary method of hospitalization for all.

Despite past achievements, the association must not rest on its laurels, Mr. Walter warned. "The survival of our present voluntary hospital system and its noteworthy accomplishments must be based upon the principles of the Blue Cross plans. The association can offer a pattern to the future which will extend the benefits of these plans to the entire population. It seems logical that this

voluntary movement which has proved to be successful and workable should be given the opportunity of extending its service to all."

Nursing is showing real leadership in postwar planning with two groups at work, one on maximum use of auxiliary workers, the other on Negro nurses, Mrs. Elmira B. Wickenden reported. The problem extends far beyond the hospital's walls.

Blue Cross

Good news for the American people —all 130,000,000 of them—emanated from Buffalo. They are all going to be able to pay for their hospital and perhaps their medical bills on a prepayment basis. But the sharpest of differences of opinion occurred over method.

Government and Blue Cross are rivals for the privilege of helping the public. While this bodes well for the public's purse, it is not yet clear what the effect will be on hospitals or the Blue Cross.

Top federal officials were present to express in the strongest and most convincing way the position of those who demand immediate nation-wide protection for all against hospital and medical bills. The Blue Cross group likewise sent their top man into the fray. So far as the enthusiastic hospital audience was concerned, he did not come out second-best. He was given an ovation that is rare in A.H.A. history. But both sides were really speaking primarily to the unseen American public.

Arthur J. Altmeyer, chairman of the Social Security Board, presented a carefully prepared and forceful argument for immediate incorporation of hospital care into the Social Security Act and for cooperation from hospitals and plans in working out some arrangement whereby the plans could continue to function in the semiprivate or private field.

While paying tribute to the 12,000,000 present enrollment, he called it "by and large the easiest 12,000,000," a statement immediately challenged by E. A. van Steenwyk, the Blue Cross champion.

ALTMEYER: Indifference and lack of foresight are barriers that cannot be hurdled by voluntary selling.

VAN STEENWYK: The enrollment of the entire population through methods that will be devised in a concerted program of the federal government, the states and voluntary plans poses difficult problems. But they are not nearly so difficult as the problems faced by the plans ten years ago.

ALTMEYER: The 1 per cent tax for hospital service proposed by the Social Security Board would bring in about $900,000,000 annually as compared with a total annual income now of all nonfederal general and special hospitals of about $600,000,000.

VAN STEENWYK: Hospitals are not going to receive what they now receive and in addition receive the amount of the Social Security tax. Will counties, cities, community chests and individuals continue to support hospitals? What part of the amount now paid by patients will continue?

ALTMEYER: Utilizing present machinery, added government administrative costs should not be more than 5 per cent of disbursements to hospitals or from one third to one half of the operating costs of Blue Cross plans.

VAN STEENWYK: Voluntary hospitals and voluntary plans must have faith in their future and the courage to utilize fully all of the strengths of the voluntary system. Their methods will take longer but are sounder. The die is cast once a compulsory system is under way. There is no turning back.

ALTMEYER: The social insurance proposals offer no threat to the voluntary hospitals. On the contrary, by offering a new assurance of income, these proposals would give renewed strength to all the hospitals and enlarged opportunity for community service. There is nothing in the proposals which intends that the system shall interfere with hospital operations or invade the field of hospital administration properly reserved to the individual institution. The best assurance we can give is again to invite the active participation of hospital people in the development of the social insurance plans.

ARTHUR J. ALTMEYER

VAN STEENWYK: Compulsory health insurance involving the entire population will require the federal government to own the hospitals and hire the personnel. Prudence in public management has no alternative.

The hope that is being dangled before hospitals and the public that they can have a compulsory system and still maintain the flexibility, economy and efficiency of voluntary local organization is futile. The choice before hospitals and the people narrows down to what kind of life they desire.

ALTMEYER: The present growth in Blue Cross plans represents a net increase of 2,400,000 a year. At this rate, how many years should elapse before a decision is made that something should be done for eight or nine persons out of each 10 in this country?

VAN STEENWYK: Blue Cross plans can become the means to satisfy the hospital needs of every citizen if we have the will to utilize them fully. Several states have an enrollment of more than 15 per cent of their population while plans in three states have enrolled nearly a quarter of the population. What can be done in one place can be done in others. To say because Blue Cross enrolled 2,500,000 last year that the rate of growth will remain at this level is against all human experience.

There is no reason to assume that, if voluntary hospitals fully support Blue Cross plans, they cannot enroll all self-supporting wage earners. If the federal government will then aid states to subsidize the enrollment of those less able to pay, all of the gains that a federal compulsory plan might obtain may be blended with the gains of voluntary management and control.

ALTMEYER: It has been suggested that the proposals to extend hospital insurance to most of the population be laid aside for the present and that, instead, federal aid should assist in providing hospital care for the aged poor. This is no substitute. The needs of from 100,000,000 to 125,000,000 people are not to be met by improving provisions for a few million who are needy.

VAN STEENWYK: We agree that additional federal aid is desirable. But this does not lessen the need for careful planning for voluntary agencies.

In addition to aiding the needy, the federal government should: (1) aid in constructing needed hospitals in rural or rapidly expanded communities, (2) extend social insurance benefits to employes of nonprofit agencies, farmers and other groups, (3) permit pay roll deductions for federal employes participating in Blue Cross plans, (4) expand the cooperative arrangements between Blue Cross plans and the Farm Security Administration, (5) start other experimentation for low income groups to blend the purposes and aims of the Social Security Board with the program of the Blue Cross plans.

ALTMEYER: I thank the American Hospital Association for the cooperation already given us in studying the social insurance plans for hospitalization benefits. Again I extend our cordial invita-

tion for continued joint study and for collaboration in the development of sound and useful plans to be considered by Congress. Our problems can be met through fair, reasonable and practical solutions by our working together. All of us have only the public interest to serve.

VAN STEENWYK: Hospitals and plans have listened in vain for practical suggestions on cooperation from the Social Security Board. If voluntary agency cooperation is needed, voluntary agencies should do their share of the planning. Federal government should not undertake what the people themselves without government can do. Close integration of nonprofit plans with the government on these problems is entirely possible if there is good faith in the constantly reiterated proffer of cooperation on the part of government. A positive program, if brought to Congress by the hospitals, would probably find Congress sympathetic and willing to listen.

Nursing

Along the Mississippi levee at the St. Louis convention last year could be heard the low rumbling of troubled waters. This year at Buffalo the rumbling had risen to a roar, as powerful and tumultuous as the falls of the green Niagara.

There are some who think that hospitals might have checked the flood of depleted personnel if they had cocked an ear toward those first rumblings for as Sr. Loretto Bernard of St. Vincent's Hospital, New York, shows in her study of 12 Eastern states nurses have left in greatest numbers to jobs in industry, military service comes second in the 428 reporting hospitals and marriage and pregnancy come third.

Personnel shortages prevail throughout hospital departments but all other losses pale beside those in nursing. Some hospitals in New York State have lost as many as 90 per cent of their nurses. More than one third of the hospitals in Pennsylvania have lost from 50 to 60 per cent of their nursing staffs.

Why? Sister Loretto Bernard asked that and found from the hospitals that nurses wanted higher pay or shorter hours or easier work or higher education. Salaries were the determining factor in 39 per cent of the departures in the 12 states studied. That factor topped the list.

While a few die-hards among the administrators censured the nurses for their excursions into industry and public health and other nonmilitary service, many were willing to admit that with higher salaries, better staff organization and pleasanter living conditions the wartime situation would be much less acute.

ELLA HASENJAEGER

Most of them, it is apparent, are learning personnel practices the hard way.

The registered nurses that certain administrators find it hardest to forgive are the special duty nurses who can't by patriotic appeals be won over to general duty.

What with the government's new nursepower distribution program, the rise of volunteer and paid nurses' aides, increased student enrollments through the U. S. Cadet Nurse Corps, today's situation is anything but static.

That the nurses have approached their war problems more resolutely and more consistently than hospitals did in the earlier part of the war is acknowledged by Dr. Claude B. Munger in commenting on the fine work of the National Nursing Council for War Service directed by Mrs. Elmira B. Wickenden. At the present time the nurses and the hospital associations are cooperating impressively, Doctor Munger points out.

SISTER LORETTO BERNARD

New to the convention was the work being done by Ella Hasenjaeger's committee on the use of nonprofessional workers on a paid basis. Miss Hasenjaeger has reviewed existing conditions in France, New Zealand and Britain and recommends licensing legislation in the various states as a control over these lesser skilled nurses, or nurse assistants.

Veronica Miller of Henrotin Hospital, Chicago, is fearful of the emotionalism of most war-time legislation and, in discussing Miss Hasenjaeger's licensing suggestion, recommended that it wait for postwar solution.

What will be done with the Red Cross and other volunteer nurses' aides when victory is won does not worry nursing leaders. Their patriotic fervor will wane, their incentive will be spent, Miss Miller believes. Miss Hasenjaeger suggests their use for letter writing, shopping for patients, answering telephones, running errands and, especially, in caring for the mildly ill and chronically ill, who never have received enough attention.

Stella Goostray, president of the National League of Nursing Education, is not troubled over governmental control over subsidized nursing schools. Another bogeyman is that through the cadet nurse corps there may be an attempt to make all schools follow one pattern. She is concerned, however, over the hospital's need for making every instructor and every graduate nurse on the staff acquainted with the necessity for the accelerated program in nursing education since every member of the staff must share in its responsibilities.

The league is also concerned over the availability of clinical facilities for the increased enrollments. It sees in the continuation and extension of affiliations one solution to taking care educationally of the increased number of students. It believes the general situation will be better if a school that offers both a basic and an affiliating program will increase the number of affiliating students rather than the number of students in the basic course.

At an A.H.A. business session the house of delegates approved recommendations of its joint committee with the National Nursing Council for War Service, which will:

1. Limit the use of private duty nurses to those in actual need, with the hospital administrator acting as adviser to the director of nursing in setting up definite criteria for the hospital.
2. Use part-time nursing service whenever proffered.
3. Pool educational facilities of schools of nursing in communities where difficulties exist.
4. Give preference in the admitting office to patients that require acute medical and surgical care.

Arrangements are being made for the U.S.P.H.S. to contract with the A.H.A. to provide guidance and coordination in the work of setting up every hospital in the United States as an information center for the cadet nurse corps and to coordinate the nurse recruitment program and help in transferring surplus applicants to areas where needed. It is thought that a small staff may work at A.H.A. headquarters. Much of the work will be done by mail through the state and regional hospital associations.

Additional discussion of nursing problems will be found under the heading "Manpower."

Personnel

Personnel difficulties naturally occupied a large percentage of the attention of all hospital people. Around the luncheon table, in the lobbies and at practically all of the formal sessions, the problems and difficulties of keeping up reasonable levels of personnel quotas were gone over again and again.

The problems were well set forth at the Monday afternoon general session by Dr. Wilmar M. Allen, director of Hartford Hospital, Hartford, Conn. Hospitals must find new workers or cut a service that has already been greatly streamlined, he said.

Pointing out that demands for hospital service had increased from 20 to 50 per cent in four years and that hospitals now have far more paper work and bookkeeping than before, he said that the manpower in hospitals has been steadily declining with from 15 to 50 per cent of the medical and nursing staffs in the armed forces and many nonprofessionals gone to Uncle Sam or to war plants.

"The remaining employes have worked harder and longer, luxuries and frills have been eliminated and volunteers have responded valiantly," he continued. But we've reached the point where these aids no longer meet the need.

Old retainers are leaving because of fatigue and better wages elsewhere, there are no more luxuries to eliminate in many hospitals and the supply of volunteers is running out.

The problem is so big and important that Doctor Allen thinks it should command the attention of the highest authorities of the United States—Army and Public Health Service—and of the medical and nursing professions. His specific suggestions were a universal selective service act, better use of available manpower in the service of the nation and rearrangement of high school schedules to permit pupils to work half days in the local hospitals.

The sectional meeting on personnel administration was one of the best attended of the morning sessions. Following the meeting, hospital administrators gathered around the speakers to pump them further, especially Dr. Clifford T. Perkins, who presented a new program for the payment of hospital employes under the intriguing title, "Pay-as-You-Live Plan."

Doctor Perkins' plan, which was prepared for the state mental hospitals of Massachusetts, where he is commissioner of mental health, is designed to link hospital salaries effectively to both the cost of living and the standard of living. Thus, the salaries will go up as these figures go up and will come down as these figures fall. Time and a half is paid for overtime. It is not possible in this brief summary to give all the details and his paper will doubtless be published. Some aspects of the plan are designed particularly to meet the needs of governmental institutions and a still more flexible plan could be adopted by voluntary hospitals.

One interesting fact brought out by Doctor Perkins is that not more than 64 per cent of the cost of living of employes with full maintenance is met by the hospital, since they still must pay for their own clothing and sundries "from their relatively meager salaries."

A distinctly hopeful note was sounded by Mrs. Lois D. McCoy, personnel director of Massachusetts General Hospital, Boston. Mrs. McCoy represents the rapidly growing group of trained, experienced personnel officers who are coming into the hospital field and demonstrating the values of present day personnel practices.

If hospitals will be flexible in their planning of jobs they can find many people who will be willing to work four hours at a time for from one to six days a week. Some of them will later, perhaps, become full-time workers.

CLIFTON T. PERKINS, M.D.

The principal sources of such workers, Mrs. McCoy has found, are schools, women's clubs, church groups, advertising columns of newspapers, handicapped groups, exit interviews with employes who are leaving and relatives and friends of present employes and of applicants. It's not a question of merely accepting those who come to the hospital personnel office, however. Mrs. McCoy made it plain to her attentive audience that someone has to go out and find these workers.

After employes are found the problems are only half solved because they must be fitted into the hospital organization and made sufficiently happy to stay. This involves training, some discipline in a human and kindly spirit and recognition and appreciation for their service.

Mrs. McCoy says that wages of from 40 to 50 cents an hour are sufficient in the Boston area to hold many part-time workers even though war jobs offer far higher rates. In general, the rates paid to the part-time workers are the same on an hourly basis as those paid to full-time workers.

All of the accepted ideas for improving morale among employes should now be used, Dr. Charles F. Wilinsky of Beth Israel Hospital, Boston, told the delegates. But Doctor Wilinsky, like many others, came back to adequate wages as the "base for the structure of satisfactory personnel relations."

Dietetics

More serious than food rationing and shortages is lack of manpower in the hospital dietary department.

Margaret Gillam, director, department of nutrition, New York Hospital, New York City, Lenna F. Cooper, chief, department of nutrition, Montefiore Hospital, New York, and others reviewing the situation from every angle placed what hope there is in attempts to educate the worker as a stimulus and to glamourize the service generally.

Apprenticeship, too, was considered and although training for the job is a slow process Miss Gillam believes it to be cheaper than the cost of labor turnover. This might be achieved through arranging a series of lectures by department heads.

There is every indication that dietitians will be depending more and more upon volunteers. The course for dietitians' aides sponsored by the American Red Cross and the American Dietetic Association is rapidly gaining momentum and enthusiastic reports were made on the success of canteen workers in various hospitals.

Groups of men volunteers may find satisfaction in serving the need that is

MAJ. HELEN C. BURNS

apparent in practically every hospital kitchen. These volunteers are said to be willing to take over any job no matter how menial. All agree, however, that they must be encouraged and made to feel that they are needed.

There is promise, too, in the part-time worker. Four hours a day, even, is better than none at all.

Effie May Winger, chief dietitian, Rochester General Hospital, Rochester, N. Y., cannot say too much in favor of the canteen workers. "They will do everything required of them," she stated, "even to going into the vegetable room and assisting in the preparation of food." At present, Miss Winger has three of these volunteers assisting her daily.

Menus must be simplified in line with the times. Garnishings are definitely out for the duration.

It is encouraging to note that some of the old employes who were wooed and won by higher wages elsewhere are now returning. The hospital offers more favorable working conditions and greater security than industrial enterprise, they have discovered.

Volunteers have given three hundred hours a month this summer to the dietary work of Edward J. Meyer Memorial Hospital, Buffalo, N. Y., Ursula S. Senn, chief dietitian, reported. Miss Senn has simplified not only her menus but her records where possible.

The problems of food rationing and distribution were discussed by Charlotte Chatfield of the War Food Administration, and Margaret M. Fotheringham, home economist, Erie County Department of Social Welfare, Buffalo. Miss Chatfield stressed the importance of making the maximum use of civilian food supplies, following which Miss Fotheringham pointed out that we have no greater problems in getting a balanced diet under rationing than we did previously.

"We'll have to change our food standards and think more of alternates. We should eat the foods we need and like them if possible."

Miss Fotheringham urged that increasing attention be given to waste, suggesting that in cafeterias, particularly, bread might be cut in half and smaller glasses of milk might be served to hospital patients if it is discovered that they are leaving some.

College

Ground was cleared in Buffalo for the American College of Hospital Administrators to go forward even more vigorously than in the past with its program for the education of hospital administrators.

Three things contributed to this: (1) a clearer understanding with the A.H.A. as to mutual responsibilities and powers, (2) presentation and approval by the regents of the work of Dr. Arthur C. Bachmeyer's committee on educational policies as the basis for a working policy, and (3) announcement of special grants with which the A.C.H.A. can carry forward its educational program.

While the joint A.H.A.-A.C.H.A. committee was continued, it seemed to be the consensus of those "in the know" that most of the really knotty questions had been satisfactorily settled and that reasonably clear and definite boundaries had been marked. Under this arrangement the A.C.H.A. will take over the Chicago institute which has been conducted by the A.H.A. Both organizations will probably work together in assisting Latin American institutes.

The A.C.H.A. authorized a separate committee to promote and supervise institutes. Ada Belle McCleery of Geneva, Ill., was named chairman of this important committee.

Doctor Bachmeyer's committee suggested that the institutes might have reasonably fixed locations and be financed by the college, which would also obtain university cooperation, select directors, supervise general publicity and assist with local publicity. It was recommended that nonmembers of the college be admitted to institutes on endorsement by two fellows and approval by the institute committee, but that administrative institutes be kept primarily for administrators rather than for department heads.

Careful selection of the institute faculty with compensation for its services, if possible, gives better control of the course content, the committee declared.

A second field of interest explored by this committee is the reading or home study course for department heads and other students of hospital administration.

CLAUDE W. MUNGER, M.D.

The committee recommended that additional universities in certain selected hospital centers be stimulated to give organized courses in hospital administration similar to those at Northwestern and Chicago.

A.C.H.A. fellows were not forgotten. The committee recommended conferences to which only fellows would be eligible to deal with the broader problems of social organization. Leading political scientists, sociologists, economists and other persons of like caliber would be invited to review trends of current thought and the place of hospitals in a changing society.

The newly installed president went beyond the recommendations of the committee on educational policies and urged the college to consider sponsoring separate institutes for department heads and specialty groups in the hospital. "It is possible that the college has too narrow a sphere of influence," Dr. Robert H. Bishop stated. Certainly, every opportunity should be taken to increase its prestige.

An outstanding program on education for hospital administration was presented by President Edward A. Fitzpatrick of Mount Mary College, Milwaukee, now a lieutenant-colonel attached to the Procurement and Assignment Service, Isabel M. Stewart, professor of nursing education, Columbia University, New York City, and Dr. William A. O'Brien, director of postgraduate medical education, University of Minnesota. They discussed the place of formal education, nursing education and continuation study, respectively, in training for hospital administration.

Five members were advanced to fellowship in the convocation exercises of the college and 29 to membership. Seventeen were accepted directly as members

and 29 as nominees. Certificates were conferred by Joseph G. Norby, retiring president. Three honorary fellowships are listed elsewhere in this issue under "awards."

Trustees

Increasing responsibilities of hospital board members in meeting both present and postwar problems were indicated by speakers at the trustees' section, including Dr. Joseph C. Doane, medical director, Jewish Hospital, Philadelphia, who described the composite boards of our voluntary hospitals as representing a great force.

He said: "Both men and women occupying positions on these boards must realize that they are responsible for every action, business or professional, that is taken in hospitals from day to day. Now is the time to engage in postwar planning, taking under advisement what not to do as well as what to do. Are we going to rebuild, repair, or neither? In reaching these conclusions a little Yankee caution will go far. It is better to base our planning on income derived during ordinary days rather than during a boom period, waiting until after the reconstruction period except, perhaps, for major repairs."

Can we have total security through taxation? Dr. Rollo E. Packard, president, board of trustees, Woodlawn Hospital, Chicago, believes not. "No nation has been able to tax its people to total security. Freedom cannot thrive under such a program. We do not want either republican or democratic bureaucracy."

A picture of hospitals bereft of a considerable portion of their vast army of volunteer workers was presented by Dr. Frederick T. Hill, chairman, board of trustees and medical staff, Thayer Hospital, Waterville, Me. Already Doctor Hill sees a slacking in the interest of these patriotic men and women and believes that sooner or later they will return to their families, leaving the women's auxiliaries to carry on. The effect of this tremendous contribution of public effort will be far reaching, however, and will influence materially public relations in the future.

Doctor Hill pointed to the possibility of attendant nurses taking over some of the work heretofore done by graduate nurses.

Will we have nursing craft as part of the hospital manual? If so, suitable standards must be established in which it is to be hoped that the nursing profession will participate with an open mind. The use of attendant service should be carefully studied despite the contingency of more abundant numbers of graduate nurses resulting from the expansion of training facilities and shortening of training periods.

Preparing a hospital budget is no sinecure. We have Frederick T. Muncie's word for it. Mr. Muncie carries after his name the initials C.P.A. and serves as comptroller, St. Luke's Hospital, Chicago. What is more, it requires more cool-headed thinking now than ever before.

A budget, to mean anything, must be based upon past experience, present conditions and contemplated changes. Another point to remember is that the more complete the breakdown of figures the more satisfactory the results. Whereas the small hospital does not require as elaborate a setup as the larger institution it might well pattern its procedure after the latter.

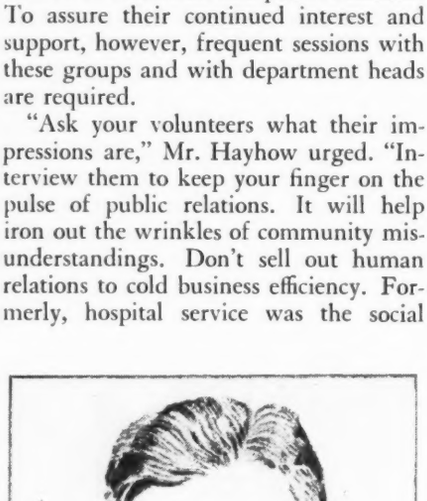
Serving as secretary of the trustees' section, as well as being its presiding officer, was James F. Stiles Jr., member of the board of trustees of Victory Memorial Hospital and Lake County Tuberculosis Sanitarium, Waukegan, Ill.

Volunteers

"Who can better speak for the hospital than the public spirited men and women who are giving it their services?"

This question was voiced by Edgar C. Hayhow, superintendent, Paterson General Hospital, Paterson, N. J., in a discussion of volunteers and public relations. To assure their continued interest and support, however, frequent sessions with these groups and with department heads are required.

"Ask your volunteers what their impressions are," Mr. Hayhow urged. "Interview them to keep your finger on the pulse of public relations. It will help iron out the wrinkles of community misunderstandings. Don't sell out human relations to cold business efficiency. Formerly, hospital service was the social thing to do; today it is the sociological thing to do."



JOSEPH NORBY

Mr. Hayhow further believes that hospital volunteers will be willing to relinquish their jobs tomorrow. "But the spirit which prompted their service will remain forever," he added.

We shall be hearing more about male volunteers. Evidence based on the experience of the New Haven Hospital, New Haven, Conn., as described by Frederick D. Grave, director, New Haven Hospital Men's Volunteer Corps, indicates that "the integration of male volunteer workers into the scheme of hospital management has passed from the experimental to an indispensable. Utilization of male volunteer assistance has been demonstrated as workable on either a restricted activity or comprehensive scale."

The use of men as volunteers has now become so potentially valuable an aid in solving the manpower problem that O.C.D. has undertaken a program to enlist and train these volunteers on a nation-wide basis. This was one of the important news announcements of the convention made jointly by Dr. George Baehr, chief medical officer of O.C.D., and President-elect Frank J. Walter.

A check-up of the activities of nurses' aides in 40 sections of the country disclosed the significant fact that in May and June, respectively, 62 and 59 per cent of those who have been certified were giving their services. The average for May was twenty-four hours of service; for June twenty-three hours. This may not be typical, however, Ida McDonald, associate director of nurses' aides of the American Red Cross, warned.

The only complaint of nurses regarding these workers is that they are not dependable in the time they work. For their part, the aides contend that too frequently they waste fifteen or more minutes when reporting for work because no plan has been made for them in advance.

Miss McDonald has several suggestions to offer for getting the best out of these women. They should be acquainted with certain hospital problems. Nursing supervisors should constantly educate their staffs on the place and the function of aides.

The nurses' aides should be made to feel that they are really important. Miss McDonald feels that hospitals should express their appreciation of the work of nurses' aides by supplying them with meals and street car tokens, by laundering their uniforms and arranging for their physical examinations.

Sustained interest must be the keynote of the volunteer program and everyone concerned must be forever at it if the plan is to succeed. Florence King, administrator, Jewish Hospital, St. Louis,

has reached this definite conclusion from her own experience. Nellie Gorgas, superintendent, St. Barnabas Hospital, Minneapolis, concurred in this but added that to achieve the best results there must be proper direction with either a paid worker or a volunteer in charge who can maintain the required control.

The following rules for a complete understanding of what hospitals expect of their aides were supplied by Mrs. Reginald B. Taylor, president, board of managers, Children's Hospital, Buffalo, N. Y.:

1. Aides must be made to realize that they are "working for, by and under the professional group, thereby relieving it of much routine work."

2. They must know that the hospital demands a sense of duty and responsibility to the job they have undertaken and that by accepting it they are part of the unit and organization, which is the hospital. It must be impressed upon them that the hospital is only as "strong as its weakest part," and it is up to them to uphold all the standards of the institution in which they are serving.

3. They should know that their personal point of view should be put aside, that the work they are doing is confidential.

4. The hospital must ask and expect of them loyalty and regularity and be able to count on them for any emergency.

World Relations

In any campaign for an eventual world society of nations, public health is a spearhead, Dr. James A. Crabtree, chief medical officer of the Office of Foreign Relief and Rehabilitation, told the convention.

"The United States can provide its appropriate share of the basic health and medical supplies for reoccupied countries without detriment to our own health services and institutions," Doctor Crabtree reassured the hospital administrators assembled.

Mexico's representative at the convention, Dr. Gustavo Baz, minister of welfare, brought a vast audience to its feet in tribute to a sister American republic. He described Mexico's huge hospital construction program, including a monumental project, the Medical Center of Mexico City.

Two British representatives brought convention-goers close to the courage of our ally through its bombings, evacuations, sinkings and sufferings.

Arthur Collins, chairman of the Metropolitan Hospital, London, brought word that 500 British hospitals have been bombed to date. Countrywide, Britain's civilian war casualties have been 96,000, one in every 500 of population. In the worst month of the bombing, only 23 persons lost their reason and had to be sent to mental disease hospitals.

Comdr. H. W. V. McCall, chief of staff to Admiral Sir Percy Noble, head of the British Admiralty delegation in Washington, whose cruiser went through the twenty-three day battle of Crete and spent a year on convoy duty to Malta, spoke reservedly of his own and his country's exploits but enthusiastically of the complete friendliness, cooperation and trust that exists between the American and British navies.

Britain's navy has transported 3,000,000 soldiers over all the seas and has lost only 1400 of them. The navy's own losses in men and ships has been terrific, 491 ships sunk and an unannounced number damaged. Some 16,000 merchant sailors have lost their lives and 600 merchant vessels have gone down in supplying food and war necessities to the home and battle fronts.

"Our two navies—yours and ours—in the fire of war have almost welded themselves into one. We think alike; we act alike. As it is in war, so should it be in peace," Commander McCall concluded.

The A.H.A. created at this convention a new Council on International Relations. The trustees hope that when the Office of Rehabilitation and Relief becomes more articulate it may turn to the new council for leadership in matters of hospitalization in many of the occupied countries.

On Friday President Walter appointed Dr. Malcolm T. MacEachern as chairman of the newly formed Council on International Relations. The other members are: Dr. E. C. Ernst, assistant director, Pan American Sanitary Bureau; Dr. James A. Crabtree, medical director, Office of Foreign Relief and Rehabilitation; James A. Hamilton, retiring A.H.A. president; Father John J. Bingham, diocesan director of Catholic Hospitals, New York City, and Dr. G. Harvey Agnew, secretary, Canadian Hospital Council.

It is understood that Felix Lamela, executive secretary of the Inter-American Hospital Association, will act as secretary of this new council.

Protestants

Even with 10 past presidents in the audience, the whole convention crowd did not measure large this year. However, it would be a serious mistake to assume that the American Protestant Hospital Association is on the wane. A sizable list of new members was read off in Executive Secretary Albert G. Hahn's report, bringing the total roster up to 140 personal and 182 institutional members.

The program, even in its physical aspect, bespoke aggressiveness of purpose, for it contained the surprising total of $1750 worth of advertising in its pages.

When it came to program content the morning session dealt with today's often trying and tedious relationships with government bureaus, a subject well covered in the subsequent A.H.A. meetings, but the afternoon session was a corking good coverage of the association's own specialty, religious work in hospitals, and the informal dinner was compounded of good fellowship, thoughtful speeches and interassociation felicities to round out a day generally regarded as decidedly worth while.

The Rev. Seward Hiltner of the Federal Council of the Churches of Christ planned and carried off the effective afternoon session, calling first upon Rev. Harold Schultz of the Caroline Mission, St. Louis, for a continuation report on last year's splendid study of clergy-physician relationships in church hospitals.

Only four hospitals had made real progress in this field, some 120 other institutions reporting that in these war days both doctors and ministers were overworked without any new activities being added.

Nellie Gorgas of St. Barnabas Hospital, Minneapolis, had an interesting tale to tell of the sports writer-minister, Fred B. Tines, who is serving the equivalent of one day a week as chaplain in her hospital. The alert Rev. Mr. Tines prepares his patients for life, not for death, having noted that nowadays 95 per cent of hospital patients head for their temporal home on discharge.

The St. Barnabas chaplain attends the doctors' conference held at 8 a.m. every Tuesday, mixes with the doctors over their coffee and cookies and absorbs a little of the terminology and the point of view of medical men.

Besides looking after troubled patients he holds a half hour service for the nurses and employes at 1:30 p.m. and he is full of ideas for making the nurses' institutional life significant, having held a "She Died Climbing" memorial service for the first alumna lost in North Africa and prepared a significant souvenir program for graduation exercises. His journalistic leanings have made him the logical choice for editor of the St. Barnabas Grapevine News, a "scandal sheet" for former staff men and employes in the armed services.

From Norton Memorial Infirmary, Louisville, Ky., Supt. Arden Hardgrove brought word of the hospital's $6500 budget for the chaplaincy, covering the salary of a full-time chaplain, his part-time secretary and essential supplies. The chaplain sees all Protestant patients upon admission and determines from the initial interview whether his relationship

with a given case will be intensive or superficial.

Early recognizing the need for better devotional material for hospital patients, the Norton Memorial chaplain has prepared a prayer folder containing a pocket for material appropriate to the individual patient's psychological needs. After his first call, he writes a "pastoral prescription" which his secretary fills from material previously prepared, puts it into the folder pocket and delivers the folder to the patient. Too, the chaplain works closely with outside groups and supervises the three months' training of student ministers reporting for hospital assignments.

From Newark, N. J., Rev. John G. Martin of the Hospital of St. Barnabas and for Women and Children reported on the technical conference held last Armistice Day under the joint auspices of the local hospital council and the Neuropsychiatric Society of New Jersey. In attendance were 75 ministers, doctors, hospital administrators and directors of nursing. Held not in a hospital but in the Academy of Medicine, this conference brought great praise and a beginning of understanding between clergymen and physicians.

The dynamic Rev. Russell L. Dicks, religious and health counselor in Dallas, Tex., told the convention the story of the "G.I. Jesus Men," the soldiers' and sailors' term for the chaplains in the armed services. From his travels about camps and stations, he thinks the Navy is doing a better job than the Army in placing its chaplains. He would like to see these men more carefully selected and more adequately trained. "Bed-to-bed work" won't get the job done, he says.

The Rev. Mr. Dicks thinks that both in military and in civilian hospitals the chaplain should see selected patients only. His first list of "selectees" includes anyone: (1) facing a serious operation, (2) apprehensive over a critical physical condition, (3) facing life with a handicap, (4) going through a long convalescence and (5) in immediate danger of death.

A second less obvious list includes those: (1) who are undergoing a prolonged period of pain, (2) who are fearful, (3) who are suffering from a guilty feeling and (4) who are feeling lonely. In addition, it is the chaplain's job to foster the morale of the personnel.

In the absence of Edgar Blake Jr., the president, who was ill, Rev. John G. Martin, president elect, was master of ceremonies. He spoke against the social security program. James A. Hamilton, A.H.A. president, left his own guests at a dinner party to talk to the A.P.H.A. on postwar planning.

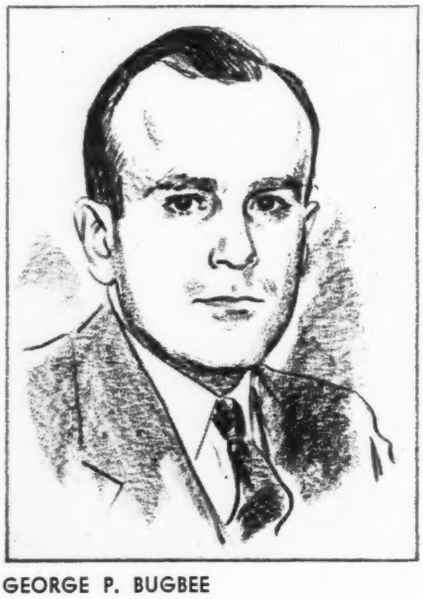
Contrary to the general opinion, Mr. Hamilton expects the postwar era to be one of conservatism, with an enforced program of economy that will make the Coolidge era look like rank extravagance. He called for a united hospital front to combat the government's social security program. Dr. Claude W. Munger described work going on down in Washington at the present time, particularly in regard to the Procurement and Assignment Service.

Awards

Judging from the applause coefficient, popular approval followed official approval in all cases in which the convention's most coveted honors were bestowed.

Certainly Dr. Arthur C. Bachmeyer's "award of meritorious service to the hospital field" met universal acclaim. The citation described him as a "distinguished administrator and educator whose achievements have greatly advanced standards of treatment for patients and educational opportunities to the lasting benefit of his fellow citizens."

Honorary memberships in the A.H.A., presented at the banquet, appropriately



GEORGE P. BUGBEE

went to men in uniform and to those who have distinguished themselves in inter-American relations.

Sonorous citations were intoned by President James A. Hamilton for former Surgeon General Hugh S. Cummings, director of the Pan American Sanitary Bureau; Col. George Baehr of the medical division, Office of Civilian Defense; Brig. Gen. Frank T. Hines, administrator of veterans' affairs and director of the federal board of hospitalization; Surgeon General Thomas Parran of the U. S. Public Health Service; Dr. Gustavo Baz, minister of welfare for Mexico; Maj. Gen. Norman T. Kirk, surgeon general, U. S. Army; R. A. Ross T. McIntyre, surgeon general, U. S. Navy, and Dr. George C. Dunham, director, health and sanitation division, Office of the Coordinator of Inter-American Affairs.

Honorary fellowships in the A.C.H.A. went to Dr. Albert E. Archer, retiring president of the Canadian Medical Association; Henry J. Southmayd, director of the rural hospital division, Commonwealth Fund, and Dr. William A. O'Brien, director of continuation studies, University of Minnesota.

In naming the National Hospital Day awards a special citation was added to compliment the Western New York Hospital Council for its successful relations with press and radio in connection with the Buffalo convention. Monsignor Albert Rung is president of the hospital council.

The Minnesota Hospital Association got the state-wide observance award; the city-wide observance winner was the St. Louis Hospital Council.

Wyckoff Heights Hospital, Brooklyn, N. Y., came out on top among cities with a population of more than 100,000. Louis Schenkweiler Jr. is the superintendent. Honors for cities between 15,000 and 100,000 went to Charlotte Memorial Hospital, Charlotte, N. C., Carl Flath, administrator.

Glenwood Community Hospital, Glenwood, Minn., the superintendent of which is Dina Bremness, received the award for small cities and towns.

Dr. Hugh Cabot, famed surgeon and a leader of the progressives in organized medicine, won The Modern Hospital's gold medal award for the year on his stimulating concept of "The Future of Nursing Education." His article was published in February 1943.

Honorable mention in The Modern Hospital's annual contest for outstanding contributions to hospital literature went to Dr. Paul A. Lembcke, who wrote "Prevention and Control of Epidemic Diarrhea," and to Catherine West, M.D., Lois Schaller, R.N., and J. Arthur Myers, M.D., for joint authorship of the manuscript, "There Is No Excuse for Tuberculous Infection," published in September 1942.

Exhibits

Maximum service to civilian hospitals —priorities, war surpluses, postwar plans —these and related subjects dominated the thinking of manufacturers participating in the technical exhibit, but always first thought centered on immediate service within the limits of our wartime economy.

The full attendance of exhibitors, which was evidenced by the fact that every bit of space was taken in the large main hall and the annex, with educa-

tional displays on the floor above, was merited by a substantial registration, considering travel restrictions and personnel shortages.

Visitors to the displays had definite objectives: orders to place, service and maintenance problems to discuss and new products and alternative materials to study. The representatives of the exhibitors were prepared to give every service with information on priorities, maintenance, shipments and related problems. Repair and maintenance of present equipment were stressed and the manufacturers emphasized the point that repair parts are available to keep present equipment operating efficiently.

One manufacturer advised that, contrary to general opinion, certain types of conveyors made with noncritical materials are now available without restriction and can be shipped in three weeks.

In the line of postwar planning a number of companies are urging placement of orders for postwar shipment of needed equipment which is not now available, the orders to be given preferential numbers as they are placed with no obligation to purchase should requirements have changed following the war.

Another exhibitor is stressing future planning through engaging architects now to prepare details so that projects will be ready for action as soon as materials and labor make it possible to carry them through.

These forward-looking plans, carefully worked out by the manufacturers, have, in addition to service to hospitals, the advantage of protecting our postwar economy by assuring continued production when government needs have been satisfied.

Although present conditions are not conducive to the presentation of new products, some items were shown for the first time at this meeting.

Among them were a vacuum-sealed bottle for storage of sterile water; cotton balbriggan pajamas for children's wards; a reclining chair, either stationary or wheeled, that provides unusual comfort for convalescent patients; new eye and skin sutures; a newly designed orthopedic frame for fracture beds; a box spring on legs for nurses' dormitories; synthetic rubber sundries; surgical instruments now manufactured in this country which, formerly, were available only through importation; special dispensers for intravenous solutions; a new form of radiation therapy; a mending kit for repairing hospital fabrics, and a mattress with an electrical motor which creates a massage motion for rest and treatment.

The educational exhibits presented a wide and interesting variety of materials from university schools of medicine, hospitals and organizations. As is always the case, the scientific note was dominant with accentuation this time on war necessities. Special features, such as the emergency medical service of the U. S. Office of Civilian Defense, attracted marked attention. Particularly worthy of mention were the valuable educational exhibits supplied by the prominent hospitals of Buffalo.

PETER WARD, M.D.

At the entrance to the educational exhibits was a large display by the Inter-American Hospital Association featuring Mexico's hospital program under the direction of Dr. Gustavo Baz, minister of welfare. It created considerable attention with its enlarged photographs of present and projected hospitals in Mexico.

Small Hospitals

1st Supt.: We're running our operating room with only one registered nurse. She's eight months' pregnant. What are we going to do now?

2d Supt.: Those giggling school girls that set up and carry the trays are so noisy that the patients and staff are distracted.

3d Supt.: The 83 year old potato peeler went home one night last week and died in his bed. And we can never send the 75 year old nurse attendant on an errand to the basement lest she fall and break her hip.

4th Supt.: I simply told our chief of staff that we wouldn't have to use one of the county's busiest doctors as a circulating nurse if he would just give up that R.N. who is making appointments and typing out bills in his own office.

5th Supt.: For two weeks the staff and help had no butter but we always managed to have a little for the patients.

Two years ago if you had told a small hospital superintendent that there was a host of problems she hadn't even met, she would stoutly have maintained that there couldn't be more. Came the war.

The brisk pace of the 1943 convention with warning bells for the long-winded and an early adjournment hour for shopping in the exhibit hall unfortunately cut short the discussion period in the small hospital section. However, in the corridors and over meatless, butterless luncheon tables the superintendents gathered in small groups to compare personnel and supply shortages and to borrow on their colleagues' ingenuity. When it came to grief and woe there was always someone with a sorrier plight so most of the administrators went home less discouraged and better qualified for the fight on the home front.

The prepared papers were of a high type. Harold Wright of Methodist Hospital, Sioux City, Iowa, gave tips on keeping the medical staff on its toes over minimum standards. He has enlarged framed photostats of various sections of the A.C.S. standards conspicuously placed so that the men can't avoid facing them now and then.

Too, Mr. Wright uses the psychological approach. "Doctor Dodd," he says, "I can't see how a man of your professional standards can neglect record keeping." Whereupon most of Doctor Dodd's contentiousness on the subject melts and he not only completes his charts promptly but makes remarks to other recalcitrant staff men.

That failing, he suggests that administrators stiffen their resolution and, with board and staff approval, withdraw the privileges of those who persistently refuse to respond to reasonable requests.

Mr. Wright recommends the use of house physicians to all small hospitals as soon as they become available. A man or woman resident who can assist in surgery will give patients the needed protection. This Iowa administrator believes that the public is now so well informed that it avoids hospitals in which only one doctor is present at any operation.

Dr. Herbert T. Wagner of Stuart Circle Hospital, Richmond, Va., sees in modern accounting methods the administrator's chief tool in economic control. Without the factual information thus obtained the hospital head cannot interpret the hospital's need to the public and widen its base of support. Nor can hospitals in a single community prove to Blue Cross and commercial insurance companies the need for increased rates unless they have a uniform accounting system. Calculation of the data now required in making reports to government agencies necessitates a standardized accounting system, such as the A.H.A. provides.

That private insurance companies are imposing on hospitals in the matter of bookkeeping and filling out record forms is Doctor Wagner's contention. He hopes that the A.H.A. can evolve a standard procedure acceptable to all hospitals and insurance companies.

In these days of technician shortages, the pathologist at Ellis Hospital, Schenectady, N. Y., Dr. Ellis Kellert, gave small hospital administrators his views on some of the procedures that can well be omitted during war time without serious loss to clear diagnosis.

Doctor Kellert would eliminate all routine orders for tests, such as the complete blood count. He would omit routine clotting and bleeding tests in tonsillectomy cases. He would omit specific gravity determinations except in special instances. He would omit metabolism determinations. Instead of blood chemistry, he suggests only nitrogen and sugar tests. In all, he would substitute simple methods for difficult ones.

Use can be made of 14 and 16 year old school girls in the laboratory on a part-time basis. Pupils recommended by their high school science teachers can work as assistants in doing urinalyses and blood counts. Older women can be employed. College trained matrons in the community may be persuaded to spend a few weeks to obtain training in some large laboratory in order to help out the local hospital in hematology and basal metabolism work, thus freeing the full-time technicians from monotonous routine.

Hospitals that can no longer find technicians will have to use the mails or a special messenger service for tests, sending specimens to clinical pathologists in near-by cities, Doctor Kellert declared in conclusion.

That carefully trained attendant nurses are ideal for the small general hospital is the opinion expressed by Katherine Shepherd of Boston, who has been training these girls for twenty-five years for both home and hospital service. She no longer has many girls for her twelve to fourteen months' course but is using older women.

The ideal ratio in a 65 bed hospital with 25 bassinets, for example, is 18 student attendants to 14 regular nurses. Massachusetts General Hospital uses two attendants to nine nurses. Without close supervision these attendants constitute a danger as in their ignorance of science they are willing to attempt any task, Miss Shepherd asserts.

Her practice is not to burden student attendants with any knowledge that they will not need in their day's work.

A postwar future for these attendant nurses may be found in chronic disease hospitals, especially in those established for the long-term care of war casualties, it is believed.

Construction

With the war won, hospital construction will take not only a sharp upturn but an amazing new turn.

Some forward thoughts on the subject of housing the health services of the community took words at the construction and mechanical section and to publish them in their interesting entirety would take a fair sized and highly provocative book. Let's dip here and there in these unpublished pages to get a little insight into the hospital building of tomorrow.

Joseph Neufeld, New York architect, sees present hospital planning as more advanced than other aspects of community planning and in the habit of working out its problems quite independently of other neighborhood needs. We must develop an adequate appreciation of the need of integrating hospital planning with city and regional planning schemes, he asserts.

VANE M. HOGE, M.D.

At least in the near future, Mr. Neufeld expects hospitals to veer more toward horizontal than vertical construction, although circumstances will require the two to meet each other. One type of construction does not exclude the other.

Instead of concentration into one large unit, the odds seem to favor development of smaller units, say of 200 to not more than 600 beds. Such units are not unwieldy, permit controlled supervision and encourage personal contact between staff and patient.

For this hospital of tomorrow Aaron N. Kiff of York and Sawyer, New York architects, foresees a greatly changed line of building materials. Rapid developments are anticipated in the by-products of wood as well as in light concrete and steel frames.

The synthetic plastic field, thinks Mr. Kiff, is so great in its potential development as to rival the sulfa drugs in medicine. It will provide, in conjunction with other material, large surfaces impervious to moisture and hard to mar, ideally suited for hospital finishes.

Panel and radiant heat will be with us to stay in new postwar buildings, Mr. Kiff believes.

Designers of civilian hospitals of the future will not pass by unstudied the lessons the Army has learned in its tremendous war-time growth. Col. John R. Hall of the surgeon general's office pointed out some of these lessons to a convention audience.

When in 1939 the Army began to expand it had seven general hospitals and 119 station hospitals, representing some 12,240 beds.

Contrast that with today's picture. It now has 56 general hospitals and enough station hospitals in this country to bring the present bed capacity to more than 300,000.

Newer than the early wood cantonment type of construction are the two story masonry fire-resistant units, which have been followed for reasons of economy by the Grade A single story masonry fire-resistant hospital.

New units have been placed in areas of great population and built in cooperation with the Veterans Administration so that the war disabled can be hospitalized near their homes.

Dr. Vane Hoge of the U. S. Public Health Service outlined a postwar building program of great magnitude, calculating the total deficit in beds for the country as 238,300 in all categories and the need for replacement assuming the arbitrary figure of 25 per cent obsolescence as 178,300, making a total construction problem of 416,000 beds. Translated in terms of costs, this would mean around $2,063,300,000, according to his calculations.

"Although this appears to be a formidable program, it must by every method of reasoning be considered conservative," Doctor Hoge asserts. It includes no facilities for convalescent care and none for the care of chronic diseases.

Should the federal government undertake some program of assistance to hospitals in the postwar period, it is Doctor Hoge's hope that it will be in the extensions of facilities and services in rural areas.

Architects present at the section meeting showed keen interest in the slides of hospitals and other health facilities being constructed in Mexico presented by Dr. Norbert Treviño, chief of the study commission of the Mexican Department of Welfare. The work is of the most advanced character in exterior and interior design.

Canada

War problems in Canada and, particularly, certain lessons that U. S. hospitals can learn, if desired, from Canadian experience were ably set forth by three leading Canadians who have had great influence on the development of hospital administration on both sides of the border.

Two of these men are A.H.A. past presidents; the third has probably trained more outstanding hospital administrators than any other person on the continent, at least two of his "boys" winning A.H.A. presidencies.

The remarks of Drs. G. Harvey Agnew, A. K. Haywood and George F. Stephens were, therefore, given special heed.

Gently but effectively both Doctor Agnew and Doctor Stephens chided their colleagues in the United States for taking an attitude of outright opposition to compulsory health insurance instead of helping to draft a bill that would safeguard and strengthen the voluntary hospitals.

Doctor Stephens, after reviewing many war-time governmental controls, put his mild warning thus:

"It is the policy and practice of the Canadian Hospital Council in matters affecting hospitals to work with, not against, the government, to steer and advise not to oppose legislation or orders-in-council. This policy has paid substantial dividends in favorable treatment for hospitals and in official good will."

Doctor Agnew's entire paper was devoted to health insurance trends in Canada. He reported the main provisions of the draft bill on health insurance as given in "Headline News" of this magazine for July.

"Nowhere in the world to our knowledge," he said, "with the possible exception of Russia has such a fine public health program been included in a plan of health insurance."

Many bodies were invited to make recommendations to the drafting committee. Doctor Agnew reported, not without pride, that the Canadian Hospital Council was the first to do so.

In general, Doctor Agnew believes the draft bill is fair to the hospitals and is supported by them in principle. Some hospitals would prefer to have action wait till after the war. The hospitals would withdraw their support, should revisions be made later that would lower the quality of service.

Doctor Agnew, who may be somewhat more optimistic than some of his colleagues, believes that philanthropy toward voluntary hospitals will increase if the present bill is enacted. Discriminating donors will be impressed by reasonable supervision of hospital expenditures and methods of operation, reduction of overlapping and assurance of adequate current revenue, in his judgment.

Although he believes that Canadian Blue Cross plans will either die or be restricted to a limited service, he stated that their growth has not been so rapid or their benefits so broad as to satisfy public demand.

A sharp line is drawn by the Canadians between compulsory health insurance and state medicine. They favor the former and oppose the latter.

"We take the viewpoint, "Doctor Agnew said, "that compulsory health insurance is more likely to evolve into state medicine and through a disastrous series of transitions, if our professional bodies and hospitals do not step in during this formative stage and lend their invaluable expert knowledge to the drafting of the plan. Only by so doing can we be assured of a measure that will be fair to the public and to those giving the service, be workable in detail, be actuarially sound and preserve as many as possible of the finer traditions and principles of our voluntary system."

A recent survey of all hospitals in the dominion reveals that they have had an average increase in daily census of 18.9 per cent from August 1939 to January 1943. Full-time personnel has increased 10.8 per cent and part-time personnel, 35 per cent.

These figures were revealed by Doctor Stephens, who pointed out that the true situation was much worse than the figures show because of shorter hours, replacement of trained workers by inexperienced and often uninterested persons and rapid personnel turnover.

The largest increase of full-time workers was among paid ward aides, who increased by more than one half. Full-time pathologists showed a decrease of 7.6 per cent.

The trials and tribulations of a hospital administrator trying to build a new addition in war time were graphically portrayed by Doctor Haywood. In spite of all difficulties, however, the new addition will open in October, with practically no substitutions.

Medical Staff

The medical staff section, although largely concerned with present day problems of hospital and staff, concluded that it is not possible to view these problems except in the light of the past and the probable developments of the future.

In discussing recent tendencies in the length of hospitalization, Dr. Benjamin W. Black of Oakland, Calif., pointed out that the hospital stay at the opening of the present war was approximately one half as long as it was 40 years ago. This is due to greater efficiency of professional medical care.

Much more speedy reduction has been accomplished during the last two years. Maternity and surgery stays have been brought down to the absolute minimum consistent with good care of the patient —often four days for maternity cases and a reduction of from five to seven days in surgical cases. When this is done with due consideration of the patient's medical and social background, no untoward effects have been noticed.

Further reduction in medical cases is possible through prompt completion of diagnostic procedures. "Professional understanding, interpretation and encouragement will permit this practice to continue until the emergency is over," Doctor Black said.

Most of us are just feeling sorry for ourselves when we talk about medical staff shortages, in the opinion of Dr. Fred G. Carter of Cleveland. Except for some hospitals with closed staffs, a few teaching institutions, some of the larger strictly charitable hospitals and some smaller hospitals in areas of severe community-wide shortages, the losses are only from 15 to 40 per cent. But most voluntary hospitals in urban areas in peace time were decidedly overstaffed from the standpoint of actual need, Doctor Carter declared.

Doctor Carter's suggestions for meeting real medical staff shortages included: (1) encouraging specialists to revive dormant skills in other branches of medicine, (2) reabsorbing clinic subspecialties into general clinics of the parent specialties, (3) eliminating all medical meetings that are not absolutely essential, (4) reducing medical records to the basic essential and (5) providing quarters in the hospital for men who are doing large amounts of emergency practice.

Most of the war-time medical organization problems of the small hospital are mere accentuations of peace-time problems, according to Keith Taylor of Oakland, Calif. Well-organized and fully attended staff meetings, good medical records and smooth relationships between staff and hospital have seldom been completely achieved in peace time. He urged hospitals to recognize organization as a means to an end, not an end in itself. Bypassing of the administration in relations of staff and trustees does not offer much hope in matters concerning all three, he pointed out. More practical is the use of a coordinating committee.

In a paper read by Charles Auslander, Dr. Herman Smith of Chicago urged hospitals to be ready to adjust promptly to the new 9-9-9 internship and residency plan and to put more real teaching content into the internship since so few men can go on to residencies.

The importance of O.C.D. work to

date was stressed by Col. George Baehr. The hospitals of the U. S. have already trained or have in training 115,000 nurses' aides and the goal has now been put at 150,000. In the blood plasma program, 168 hospitals have been assisted in establishing banks. They are accumulating 80,000 units. With other frozen and dried plasma now on hand, the total reserve amounts to more than 150,000 units. These plasma reserves were very helpful in the Cocoanut Grove, Pennsylvania R.R. and Lackawanna R.R. disasters.

While Colonel Baehr threw no verbal bombs such as those at St. Louis, he did announce at this session that O.C.D. now requests the collaboration of the A.H.A. in a nation-wide program to obtain help of reliable men volunteers. He asked the A.H.A. to name three members of a national committee to formulate and promote the program. Effective recruiting methods, a distinctive name, a distinctive coat or uniform, guidance on training and other details need to be decided upon by such a committee.

Councils

To get the work of the association off to a flying start, President Walter called a meeting of the new board of trustees on Friday so that his appointments could be ratified promptly and the councils get to work. All the old councils have the same chairmen as last year, except that Oliver G. Pratt succeeds Ada Belle McCleery as chairman of the council on association development. The personnel of the newly formed council on international relations, headed by Dr. Malcolm T. MacEachern, is given elsewhere in this issue.

The A.H.A. members of the joint committee of the three national hospital associations are: President Frank J. Walter, Dr. Claude W. Munger and Dr. Charles F. Wilinsky.

Appointments to other councils are as follows: administrative practice, Nellie Gorgas and Dr. W. Franklin Wood; professional practice, Dr. R. C. Buerki (reappointed and named chairman) and Dr. M. H. Rees; planning and plant operation, Carl P. Wright Jr. and Paul L. Fesler; public education, Dr. George O'Hanlon (reappointment), E. I. Erickson and E. Muriel McKee; government relations, Dr. Claude W. Munger, Msgr. Maurice F. Griffin and, as a consultant, Dr. Charles F. Wilinsky (all reappointments); association development, Oliver G. Pratt (reappointment) and Kenneth Williamson.

As a result of these appointments, there are 10 new persons on A.H.A. councils, four have been shifted from one council to another and five have been reappointed.

Out-Patients

Trends noted last year continued to demand the attention and thought of administrators and supervisors of out-patient departments, a small but select group of whom gathered at Buffalo. Continual change in conditions, personnel and demand for service call for constant re-evaluation of this service.

The volume of service rendered continues to decrease especially in industrial areas. Coincident with the slackening demand for free service has been a growing demand for a service for pay patients.

Some of these hospitals have met this demand by an upward adjustment of the income scale for eligibility to the clinic, others by providing office space for physicians to treat this class of patients. One speaker cited the example of an out-patient service for both pay and indigent patients in a rural area. Physicians in this section refer pay patients to this clinic. This is a significant trend.

Payment to clinic physicians for their services, long opposed at times by physicians and medical organizations, appears to be another marked trend. In many instances the shortage of resident house officers has created a problem in staffing the clinic. It was recognized that payment to physicians for service in clinics was fair and it is expected that this practice will continue.

The shortage of physicians, nurses and other personnel has created a problem in staffing the clinic and during the present emergency has focussed attention on out-patient service as a community problem. Although all admit the value and necessity of specialty clinics and of small clinics serving a particular area, it is questionable if it is wise to continue operation of multiple clinics. Consolidation would mean a saving in manpower. From the individual hospital or clinic standpoint, such measures as combining or absorbing clinics, use of volunteers, standardization and review of statistics were offered as ways to conserve manpower.

J. E. MOORE

The important rôle the out-patient department can play in the community health program was stressed. This is a development which many hospital administrators have neglected but one to which the thoughtful administrator will give attention in the future.

In brief, these appear to be the significant trends in out-patient service as discussed by such men as Leo M. Lyons, James E. Moore and Donald S. Smith and Drs. A. J. J. Rourke and Vane Hoge.

Public Hospitals

No punches were pulled when Everett W. Jones took on the task of discussing the relations among voluntary hospitals, government hospitals and local government agencies. Our employes by accepting low wages are contributing heavily to the cost of caring for charity patients. "What right has a hospital board, a hospital administrator or city and county officials to saddle this wholly unjust tax on hospital employes?" Mr. Jones asked.

Getting very personal, Mr. Jones wanted to know why a chauffeur for Buffalo's mayor or drivers of police or fire department cars should be paid more than hospital ambulance drivers.

He vigorously urged hospitals to take down from the shelf and dust off the report of the joint committee of the American Hospital Association and the American Public Welfare Association which was published in 1939. "Why did the A.H.A. trustees approve this report and then pigeon-hole it?" he demanded. A resolution to revive this report was passed by the audience and referred to the trustees.

Speaking from his personal experience of fifteen months in Washington, Mr. Jones declared that he is against compulsory hospital insurance under government management. "Federal agencies by their very nature cannot hope to approach private initiative and enterprise in efficient management," he declares. "Delay and red tape just can't be eliminated in any political organization as gigantic as our federal government. The record speaks for itself."

Governmental general hospitals can well accept Blue Cross subscribers if a few problems can be worked out, in the opinion of Carl M. Metzger, executive director of the plan in Buffalo. It would be more difficult to work out arrangements with the tuberculosis and nervous and mental hospitals, he thinks; he

opposes extending contracts for such care at the present time.

The problems most frequently encountered in including governmental general hospitals as Blue Cross member hospitals are as follows:

1. Payment for members of the medical staff in those hospitals where the medical staff has heretofore served without pay.

2. Avoidance of a substantially longer stay in governmental hospitals than is customarily found in voluntary institutions.

3. Guarantee of service by the member hospital even though the Blue Cross might, in event of war, epidemic or other disaster, be unable to pay. Four municipal hospitals and one state-county hospital have joined his plan, Mr. Metzger stated, and had no difficulty in working out this guarantee.

He urged governmental hospitals and local Blue Cross plans to work closely together since both have the welfare of the community at heart.

Fellow administrators of governmental hospitals were advised by Dr. Edwin L. Harmon of Grasslands Hospital, Valhalla, N. Y., to be patient with the restrictions imposed by civil service and other rules and to remember that they were usually adopted for the protection of the public. He pointed out that wartime demands may make public spirited citizens so busy that they cannot protect governmental hospitals from political interference. It is the responsibility of governmental hospitals to maintain high but not extravagant levels of service, in his opinion.

Pointing out that budgets in governmental hospitals usually must be prepared six months in advance of the year to which they apply, Doctor Harmon called for greater flexibility in making minor changes within the total funds available. "We must not abandon ourselves to an attitude of hopelessness for anything but mediocrity in performance in the public hospitals," Doctor Harmon concluded.

Pharmacy

The subtitle on the pharmacy section program should have read: "Half a Day in a Haunted House."

No doubt on the theory that most hospital pharmacists wouldn't feel at home in a comfortable and convenient environment, this small but alert group was assigned a barn-like hall with uneven flooring, trap doors, exposed pipes and ghostly knockings and groans.

These last named g.k. and g. were the only sounds that the amplifying system seemed able to pick up, while the soft-voiced substitute reader of Dr. Alexander W. Kruger's good paper on waste and the double bass of Robert F. Fuqua's masterly treatment of drug savings and war substitutes came through very choppily indeed. Florence King and J. Solon Mordell were not so handicapped by the bad acoustics.

Florence King preached at the pharmacists present to throw off their persecution complex and make up their minds to be on a professional plane with other staff members and department heads.

"Stop whining about your poor location," said she bravely, referring to their

FLORENCE KING

usual cellar position physically and psychologically and perhaps also to their temporary cavernous quarters.

"Tell the administrator that you don't mean to stop filling a prescription to sell a baby's bonnet or spread a sandwich. Make up your mind to serve as a consultant and teacher to every last department. Use the doctor's new interest in chemotherapy to convince him that you are not a drug clerk but a consulting medium."

This advice was heard with appreciation, mixed with a dash of doubt, by a group predominantly women, half of whom wore the robes of the Catholic sisterhoods. A few of the delegates had come up from the American Pharmaceutical Association convention in Columbus, Ohio, the preceding week, most of them feeling a warmer relationship with the pharmacists than with the hospital field.

One woman had spent $50 going to a pharmacists' convention two years ago and on the strength of what she had learned there was able to save her hospital $600 within the year.

There was pay dirt in the Kruger and Fuqua papers, too, much of which will have to await publication in the hospital press since it came through too indistinctly for safe note taking. Let's hope the whole picture hasn't changed before some of these ideas can get into print.

Mr. Mordell, the W.P.B. man, told of the office of civilian requirements' interest in reported shortage of health supplies. Each report is investigated to make certain that it is not a sporadic isolated instance.

"Inability to get a certain item after placing an initial order does not necessarily mean that the material is unobtainable," Mr. Mordell asserted. "Knowing that supplies have been made available for civilian use and assuming that suppliers have been intelligent about distribution, W.P.B. men have a reasonably good idea about what the market situation should be.

"Allocation and limitation orders have been effective in conserving the more critical drug items, but such matters as container materials also play a crucial part in the whole picture."

Purchasing

The purchasing section started twenty minutes late but completed its schedule at 11:45 by omitting discussion of individual papers from the floor and substituting a question period at the end. Sitting on the platform made it practically impossible for your reporter to hear the remarks made by the speakers —a gentle but effective form of torture that should never again characterize a hospital convention.

James F. Best, purchasing agent of the New York Hospital, stressed the need for standardization and elimination of unnecessary sizes and designs and suggested regular tests for items in use. Although Mr. Best's hospital prides itself on having standardized its supplies and equipment for many years, it was able during the past year to reduce the number of stock sizes and gauges of hypodermic needles from 21 to 10 and to eliminate seven sizes of rubber tubing.

Dr. A. K. Haywood of Vancouver General Hospital, Vancouver, B. C., discussed at length the supply situation in Canada, calling particular attention to the difficulties in obtaining needed supplies and the severe labor shortage being experienced there.

James McClellan, representing the Hospital Industries Association, stated that many items have been eliminated from catalogs but that the industry in general is doing its best to keep hospitals supplied with needed items. He called attention to the enormous demands from the armed services.

Kris P. Bemis, associate director, food rationing division, O.P.A., James Russell Clark, director of the A.H.A. Wartime Service Bureau, Everett W. Jones of W.P.B., and William S. Brines also of W.P.B. briefly reviewed the work of their respective departments.

Written questions from the floor brought out the following facts: (1) there is a better understanding today of the priority system than there was a year ago; (2) hospitals in general have not suffered too badly for lack of materials; (3) general dissatisfaction with the food rationing program exists because hospitals have not been given sufficient leeway in points allowed for future buying and point values assigned to certain items seem to be unfair.

Resolutions on the food rationing situation as seen by the purchasing agents were presented by Guy Clark of the Cleveland Hospital Council and forwarded to the officers of the A.H.A.

On motion of Arden Hardgrove, the purchasing agents expressed appreciation of the work of Everett W. Jones.

A "rump session" of the section was held in Mr. Clark's hotel room later in the day when Mr. Bemis met with about 20 purchasing agents to discuss the food rationing program. Several worth-while recommendations were made to Mr. Bemis, who promised to carry them to the doorsteps of the proper authorities in Washington.

Accounting

Four timely subjects were presented at the accounting section, which was well attended, by speakers carefully selected to give pertinent information useful in helping to solve problems caused or aggravated by present war-time conditions and difficulties.

William A. Dawson, administrator of South Baltimore General Hospital, Baltimore, showed how dangerous it is to assume that rates are adequate or fair now just because they were a year ago. If justice is to be done to all classes of patients and the hospital is not to suffer a loss from service to pay patients it is essential that adequate cost accounting methods be instituted and pursued energetically. In no other way can a hospital know not only its present position but also how it arrived there.

It was never more important that rates for bed, board and routine care, as well as for all special services, be adjusted promptly when current cost figures indicate that existing rates no longer produce the results desired by the administrator or trustees.

Paul C. Fahrney, budget director of Presbyterian Hospital, New York City, outlined the steps used in preparing a budget, showing how the problem is simplified by breaking it down into four parts, namely, operating income, non-operating income, salaries and wages and all other expenses. It was shown how a budget was useful as a tool in the hands of the administrator in directing the hospital's affairs so as to assure a reasonable expectation of finishing the year's operations according to policies approved by the board of directors.

A budget, to be of the most help, must be flexible and must serve the changing needs of the hospital. Yesterday's plans may have to be altered today and a helpful budget is one that is able to keep pace with these fast moving times.

An explanation of hospital employes' maintenance and the income tax was given by Robert H. Reeves, chief accountant of the Rochester General Hospital, Rochester, N. Y.

An employe who lives in a hospital for the convenience of the employer is not required to pay income tax on the value of such maintenance. As a general rule, the "convenience of the employer" test is satisfied if the employe is required by the employer to accept the living quarters or meals furnished by the employer in order to perform his duties.

The test is not satisfied when the employe at his own option accepts meals or quarters merely because he finds it more convenient to do so or when the employer furnishes the quarters or meals because he finds it a convenient way of making partial recompense to an employe who could obtain acceptable quarters or meals elsewhere and still give proper attention to his duties. This principle has been the rule for a number of years and it still continues under the withholding tax law.

When maintenance is taxable to the employe it must be valued by the hospital not at cost but at the fair market value of the maintenance furnished. The following guides may serve as some indication of the fair market value of maintenance: (1) the extra allowance given to those employes who live outside the hospital; (2) the value of comparable accommodations given in other hospitals of the community; (3) the valuation used for computing workmen's compensation premiums, which varies from $22 per month in a midwestern state to $45 per month in an eastern state, according to a recent survey.

Dr. Edwin F. Daily, director of the division of health services, U. S. Children's Bureau, talked largely on the subject of emergency maternity and infant care furnished to wives and infants of men in the armed forces. These cases now total about 50,000 and are increasing at the rate of approximately 20,000 each month. Hospitals are reimbursed through appropriate state agencies for the care of these patients at their individual computed ward costs.

These costs are computed as 85 per cent of the average cost per day for all in-patients except that this reduction is not made when a hospital furnishes care only to private patients or only to ward patients.

If a given state requires that these patients be placed in accommodations more expensive than ward, such decision is made within the state and is not a national policy.

Heretofore, the daily rate of payment to hospitals was reduced 25 per cent for long stay patients. This reduction in rates paid is no longer the rule and the appropriate state agencies are permitted to change their procedure in this regard at any time they desire.

In these days of rapidly rising hospital costs it is realized that a rate established six or nine months ago may be inadequate today. It is possible for a hospital possessing the data to resubmit its costs as often as twice a year in order that reimbursement may be based on the most recently established costs. In such cases, though, the cost statement must be for a full twelve months' period even though the alternate statements cover periods beginning and ending in the middle of the established fiscal year.

Children's Hospitals

No more enthusiastic hospital administrators can be found anywhere than those in the children's hospital section. They recognize thoroughly their responsibilities and have a strong desire to cooperate with the government in its program for child care.

George Fishback, executive secretary of the Ohio State Hospital Association, discussed the formula arrived at by the U. S. Children's Bureau for the payment of hospital cases. He pointed out that the Ohio formula is different from and more lenient than others. He felt that any group can work out its problem with any government bureau if a reasonable opinion is advanced and can be substantiated.

If either a state association or an individual hospital can demonstrate that it is impossible to operate on a $6 per diem basis, in his opinion, better arrangements can be made. Other rates for Army emergency relief were also discussed at this session.

These administrators agree that hospitals must share the responsibility of keeping up the morale of service men and this can best be done by giving their dependents the best possible care. The rate structure for children's hospitals, in the opinion of this group, should be made on a uniform basis by reporting their costs in a uniform manner. All hospitals should have definite rates and deviate from them as the administrator or medical social service department finds it expedient.

There was considerable discussion regarding the charges in communicable disease units and while there was a difference of opinion in this matter the

majority felt that a higher rate should be charged for communicable cases because of the increased cost of that department.

These people are mindful of their duties in postwar planning and feel strongly that a reduced nurse affiliation would deal a severe blow to children's hospitals throughout the nation. In their opinion it is impossible to give affiliating nurses proper pediatric training in a shorter period than is taken at the present time and that it is definitely wrong to eliminate this training from the nurses' curriculum. A nurse is improperly trained unless she is able to care for the sick child.

The group adopted a resolution objecting to the 15 per cent decrease in the per diem rate ordered by the Children's Bureau.

The section also passed a resolution to go back to the Council of Administrative Practice asking for representation on that body, if the section was to be under that council. Another resolution opposed pediatric affiliation for any term less than three months and suggested that the council send copies of this last resolution to the secretary of each state nursing board.

All members of the section visited the Children's Hospital of Buffalo while they were in the city.

Medical Records

The sectional meeting on medical records proved to be one of the best attended sessions of the entire week. George St. J. Perrott of the U.S.P.H.S. discussed "Hospital Records as an Index to National Health."

Stressing the fact that birth and death registration is not sufficient to provide a health index, Mr. Perrott described the morbidity code and manual which the U.S.P.H.S. is trying out in some institutions. The code is not designed, said Mr. Perrott, to be a nomenclature of disease and should not be so used. It is merely a device for collecting data on illness in a form that will yield uniform statistics.

Dr. Albert Snoke's message that standardized insurance forms are becoming a reality was greeted with enthusiasm, if with some incredulity. A report of the A.H.A. committee on such forms will be published shortly, Doctor Snoke said. Already, several hospital councils have adopted the forms proposed by the committee.

Stressing the fact of the doctor's responsibility to his patient for an accurate record of illness, Dr. Margaret DuBois of the A.C.S. cited as unapproved short cuts in obtaining medical records such practices as permitting the taking of histories by a nurse or office clerk and

GEORGE St.J. PERROTT

obtaining the diagnosis from the doctor verbally, having clerks put into narrative form the data from check-off physical findings and having progress notes written by the nurses.

Doctor DuBois agreed with Dr. Malcolm T. MacEachern that the best short cut to medical records is "Do it now." Doctor DuBois pointed out the danger of using volunteer help in the record library unless such people are carefully instructed in the confidential nature of medical records.

Margaret Taylor, in a masterly plea to record librarians to rise out of the rut of routine detail, showed that nearly all of the phases of an educational program for interns are logically bound up with the work of the record librarian. Through the utilization of present opportunities and without the addition of new tasks, the record librarian may contribute much more to the advance of medical science and practice.

The crowning achievement of the morning was a round table led by Doctor MacEachern, Dr. Robin C. Buerki and Dr. M. G. Westmoreland and participated in by all the speakers of the morning. Even President James A. Hamilton came into the meeting to contribute his share.

Tuberculosis

The hospital must share with the home the disgrace of being a major reservoir of tuberculosis infection. Patients with undiagnosed, as well as diagnosed, tuberculosis pass on the disease to employes. Employes take it home to their families.

Case finding and segregation aren't enough. It is imperative that a communicable disease technic be maintained at all times by all persons coming in contact with these patients.

One of the sorry sides of a hospital convention is that hospital administrators and medical directors are off in some other lecture hall while the tuberculosis men retell to one another such truths as those above.

The greatest case finding project in the history of medicine is still under way through the Selective Service examinations.

Gen. C. R. Reynolds of the Pennsylvania Department of Health gave authoritative estimates that there will be 21,750 newly diagnosed cases requiring hospitalization uncovered by the draft by the end of 1943.

Added to Selective Service tuberculosis rejectees, the cases uncovered among industrial employes by improved ease finding methods, the total will probably represent a new bed requirement of somewhere between 25,000 and 30,000.

Since the ideal arrangement for the hospitalization of the tuberculous begins with immediate provision of at least temporary care in general hospitals, the problem affects all hospitals.

A splendid system of tuberculosis control in a general hospital has been worked out in Albany Hospital, Albany, N. Y. This was described in detail at the tuberculosis section by Dr. R. J. Erickson.

Doctor Erickson decries the current view that tuberculosis work is a special and separate field. For this reason the tuberculosis problem receives scant attention in the general hospital, where tuberculous patients are admitted only by mistake or in ignorance and are sent away as rapidly as possible.

Thoracic surgery, increasingly prominent, is another reason for closer cooperation between general hospitals and sanatoriums. The tuberculosis field alone cannot support an adequate number of thoracic surgeons and it would be better if these men were members of a general surgical staff rather than sanatorium men.

How hazardous is this disease to hospital employes can be demonstrated in mental hygiene hospitals where from 3 to 5 per cent of all patients have the disease in an infectious stage.

At 20 institutions for the mentally ill in Pennsylvania, Drs. Robert E. Plunkett, George W. Weber and Frederick MacCurdy found that 1.1 per cent of the employes had clinically significant tuberculosis; this is twice the rate of infection found among industrial workers in the area.

Worse than that, employes who had worked in these hospitals more than five years showed a higher rate, 1.6 per cent, indicating that the longer the exposure the greater the risk to employes.

The consensus was that it costs but a pittance to detect these cases while it takes $8000 to care for the average case.

ASSOCIATION OFFICERS NAMED AT BUFFALO CONVENTION

American Hospital Association

PRESIDENT: Frank J. Walter, St. Luke's Hospital, Denver.

PRESIDENT-ELECT: Dr. Donald C. Smelzer, Germantown Dispensary and Hospital, Philadelphia.

FIRST VICE PRESIDENT: A. J. Swanson, Toronto Western Hospital, Toronto, Ont.

SECOND VICE PRESIDENT: Rev. Donald A. McGowan, St. Elizabeth's Hospital, Brighton, Mass.

THIRD VICE PRESIDENT: Nellie Brown, Ball Memorial Hospital, Muncie, Ind.

TREASURER: Dr. Harley A. Haynes, University Hospital, Ann Arbor, Mich.

TRUSTEES (for three years): John H. Hayes, Lenox Hill Hospital, New York; Dr. Lewis E. Jarrett, Hospital Division, Medical College of Virginia, Richmond; Joseph G. Norby, Columbia Hospital, Milwaukee; (for the unexpired term of the late J. H. Groseclose): Mrs. Josie M. Roberts, Methodist Hospital, Houston, Tex.

American College of Hospital Administrators

PRESIDENT: Dr. R. H. Bishop Jr., University Hospitals, Cleveland.

PRESIDENT-ELECT: Dr. Claude W. Munger, St. Luke's Hospital, New York City.

FIRST VICE PRESIDENT: Mildred Riese, Orthopaedic Hospital of Los Angeles.

SECOND VICE PRESIDENT: Scott Whitcher, St. Luke's Hospital, New Bedford, Mass.

Hospital Service Plan Commission

CHAIRMAN: E. A. van Steenwyk, Associated Hospital Service of Philadelphia.

VICE CHAIRMAN: John R. Mannix, Michigan Hospital Service, Detroit.

TREASURER: George Putnam, Boston.

DIRECTOR and SECRETARY: C. Rufus Rorem.

American Protestant Hospital Association

PRESIDENT: Rev. John G. Martin, Hospital of St. Barnabas and for Women and Children, Newark, N. J.

PRESIDENT-ELECT: E. I. Erickson, Augustana Hospital, Chicago.

FIRST VICE PRESIDENT: Rev. Joseph A. George, Evangelical Hospital, Chicago.

SECOND VICE PRESIDENT: Paul C. Elliott, Presbyterian Hospital-Olmstead Memorial, Los Angeles.

TREASURER: Ritz E. Heerman, California Hospital, Los Angeles.

TRUSTEES: Asa S. Bacon, Presbyterian Hospital, Chicago; Rev. John G. Benson, Methodist Hospital, Indianapolis; F. Jane Graves, Alton Memorial Hosptial, Alton, Ill.; Leo M. Lyons, St. Luke's Hospital, Chicago; Robert Jolly, Memorial Hospital, Houston, Tex., and Edgar G. Blake Jr., Wesley Memorial Hospital, Chicago.

Hospital Industries Association

PRESIDENT: Elmer H. Noelting, Faultless Caster Corp.

SECRETARY-TREASURER: E. Jack Barnes, Wilson Rubber Co.

DIRECTORS: Walter A. Collins, Simmons Co., and H. A. Nordquist, Hobart Manufacturing Company.

TRUSTEES: Lawrence Davis, Lewis Manufacturing Co., and George J. Hooper, Puritan Compressed Gas Co.

Nurse Anesthetists

The meeting of the American Association of Nurse Anesthetists was cut down to one day because of the great shortage of nurse anesthetists in the civilian hospitals. In retrospect this was wise because even with the one day meeting business could not be transacted as a quorum was not present. Letters poured in from anesthetists all over the country regretting their inability to attend the meeting and to the anesthetists we take off our hats for sticking to the job.

At the business meeting Monday morning the certification program committee reported that following the last annual meeting Dr. J. R. Clemmons, Roosevelt Hospital, New York, had been appointed by the American Hospital Association as adviser to the anesthetists' group.

During the year the certification program committee had presented plans to Doctor Clemmons for certification of anesthetists and the commitee reported that the plan that had been developed had the following objectionable features:

"That elevation of standards for membership in the association will bar nurse anesthetists who do not have the qualifications for examination, but who are practicing anesthetists. That by so barring this group of practicing anesthetists we are defeating our purpose to raise the quality of nurse anesthesia service to the extent of this group by depriving them of the educational advantages of membership.

"That by certifying the entire present active membership by waiver we are placing the highest and, therefore, the same rating on each individual of the present body of members and that, therefore, the certification program will be weakened and perhaps nullified to the extent of the percentage of the least qualified of the present membership who will be privileged to become certified under the waiver."

The committee, therefore, requested that the plans for certification of anesthetists remain in committee for further study.

Mrs. Gertrude L. Fife, chairman of the educational committee, reported that "the highly publicized demands of our armed services for nursing personnel have so severely drained the supply of graduate nurses from which comes the supply of students for schools of anesthesia that several well-established courses have been obliged to suspend functioning.

"On the other hand, a parallel shortage of nurse anesthetists in the hospital field has encouraged the inauguration of new and sometimes ineptly planned schools of anesthesia, no less than 12 having come to the attention of our committee during the past year.

"It is hoped that hospital superintendents will give their support to the well-organized and effectively functioning schools of anesthesia rather than countenance the draining of the none too plentiful supply of desirable student material into ill-advised or inadequately planned new teaching enterprises."

Officers will remain the same this year because a quorum was not present at the business meeting. The board of trustees voted to refer the certification program back to committee. A committee was appointed to investigate the Bolton Act as it applies to anesthesia. The treasurer was authorized to purchase $3000 worth of United States War Bonds during the Third War Bond Drive.

At the dinner which was held at the Statler Hotel, Dr. Earle B. Mahoney, assistant professor of surgery, School of Medicine and Dentistry of the University of Rochester, talked on "Prevention and Treatment of Shock." The slides shown by Doctor Mahoney were particularly interesting because they illustrated clearly the indications and contraindications for fluid, plasma and whole blood.

Following Doctor Mahoney's talk, a movie was shown on "Anesthesia Service to Mankind," which was developed by Esther Myers Stephenson, Mount Carmel Mercy Hospital, Detroit, a member of the association. The picture dealt largely with technics for the various anesthetics and was intended to be used as an educational film.

At the meeting two questions were paramount in every discussion. The first: "What are we going to do for anesthetists in civilian hospitals?" The second: "How are the schools of anesthesia going to function if, as was reported in some instances, there is a shortage of applications for courses in anesthesia?" Some of the schools reported that their classes were filled until the spring of 1944, but one director of a school reported that in the September class five were signed up and only one reported for duty.

An appeal was made to the general assembly at the afternoon meeting asking the anesthetists to make every effort to influence nurses to enter this field.

Buckley Pavilion

Methodist Hospital

Brooklyn, N. Y.

ADDISON ERDMAN

and CHARLES BUTLER

Architects Associated, New York City

Right: Exterior of the Buckley Pavilion. The red brick harmonizes with the existing buildings. Below: One of the sun decks that affords a panoramic view of New York City.

IN 1887 the Methodist Church completed its first Methodist Hospital, erected in the center of a city block in the borough of Brooklyn, N. Y., and consisting of three buildings connected by a pipe tunnel. From those beginnings the Methodist Hospital of Brooklyn grew into an institution of 475 beds, covering the entire block.

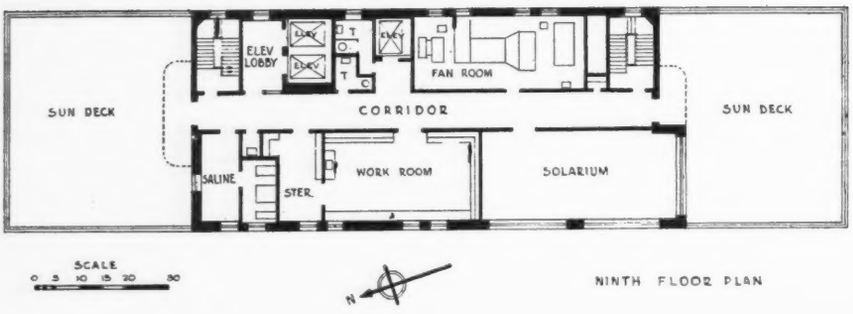
In 1940, in order to modernize and expand facilities, the board of managers decided to tear down one of the original buildings, the three story "West Pavilion," and to replace it with a nine story structure containing 144 beds, a modern surgical service, a centralized purchasing department and general storerooms. The Buckley Pavilion, completed in 1942, covers an area 180 feet long by 46 feet wide, which is larger than the original building owing to greater utilization of available space.

On the first floor the original floor level was maintained, in general, to meet existing grades of connecting corridors, pipe tunnel and the receiving entrance at Seventh Street. However, north of the main connecting corridor, the floor was dropped 1 foot 4 inches to minimize entrance steps from the Sixth Street sidewalk to the admitting department and to obtain greater ceiling height in the entrance lobby and the tearoom. The tearoom and lunch counter (reached from the main lobby through a gift shop) are for the convenience of visitors at lunch and dinner time. This northern section of the first floor also houses reception and consultation rooms and admitting offices.

Because of their northern exposure, the entrance doors are equipped with bronze hardware and set in a deep reveal. The entrance is further protected by a bronze marquee, probably the last of its kind to be built for the duration of the war. The entrance itself is of Indiana limestone with carved decorations of entwined oak and laurel branches.

The exterior of the new pavilion is of red brick, to harmonize with the existing buildings of the group, but, in accordance with modern practice, the limestone cornices and decorative features that characterized the earlier buildings have been omitted. The only decoration consists of simple brick patterns. The brick walls themselves are laid up in the same English cross bond used in the other buildings.

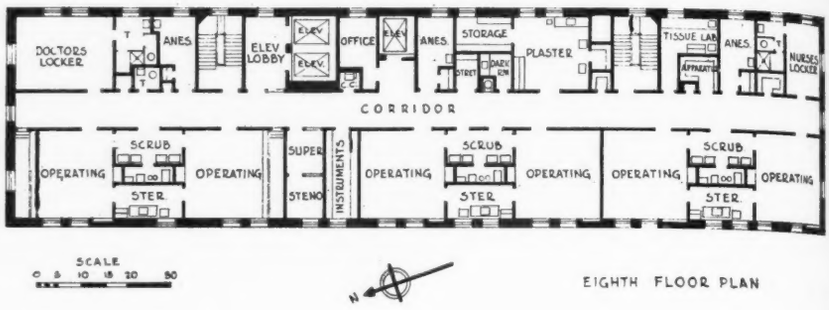
In order to avoid monotony and that "institution-look," many colors have been used throughout the building. Patients' rooms are painted light buff on lower floors and peach or green tints on upper stories, depending upon orientation. In general, floors are asphalt tile with rubber base varying in color to harmonize with the different wall colors. Corridors throughout have variegated green floors with rubber bases and green painted dado and dark green stripe. Corridors on first and eighth floors, because of heavy traffic, have green rubber wainscots and cap. All corridors and elevator lobbies have



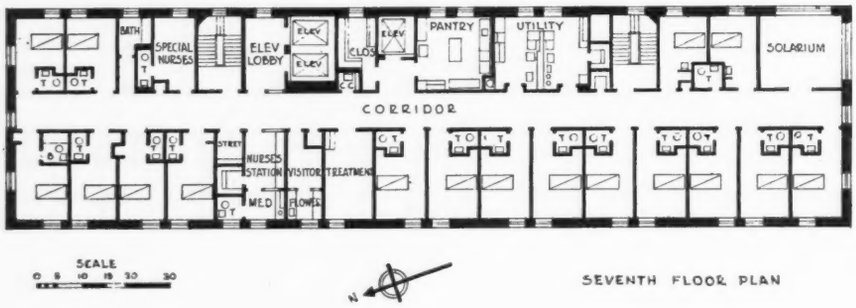
NINTH FLOOR PLAN

The ninth floor serves two main functions. One part is used for central sterilizing and work rooms for the entire hospital group, with the latest type of high-pressure sterilizers instead of the usual "boiling" type. The main portion, however, is devoted to two sun decks and a 40 by 19 foot solarium for convalescent patients and visitors.

The eighth floor, which is devoted to surgery, contains six operating rooms, a plaster room, anesthesia rooms and dressing and locker rooms, with showers and toilets. The operating rooms have gray-green tile wainscots and sage green tile floors. The heating system in the operating rooms was installed for washing, warming and humidifying the air.



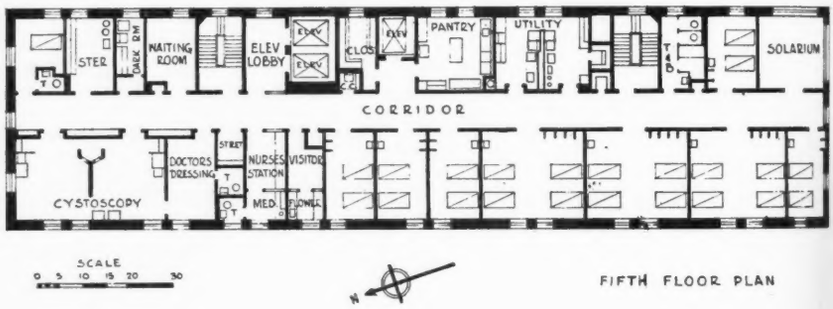
EIGHTH FLOOR PLAN



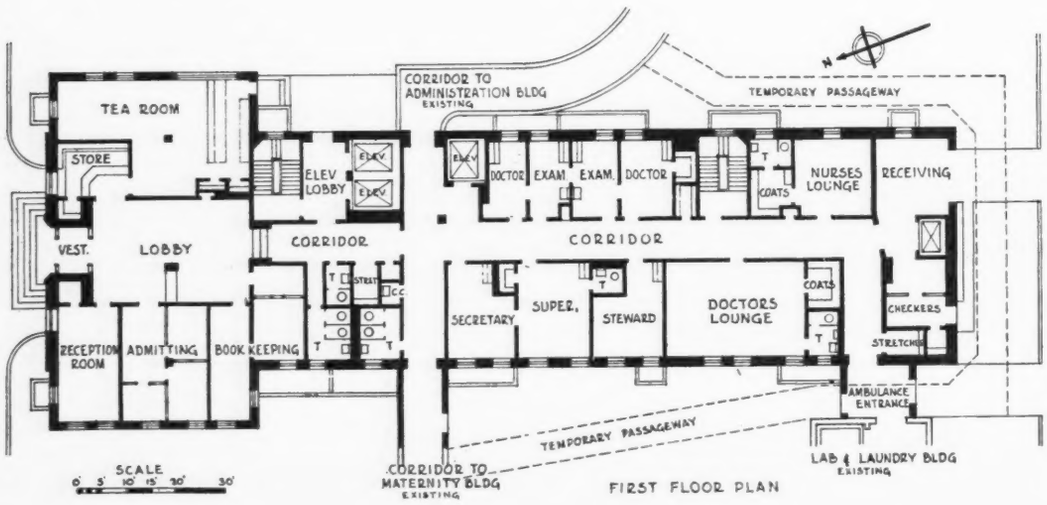
SEVENTH FLOOR PLAN

Patients' floors, from the second to the seventh, inclusive, are divided into four bed and two bed semiprivate and private rooms. Every ward room has an exposed lavatory installed with combination spout and elbow control faucets. These fixtures have rubber wainscots behind them to blend with the color scheme of the room instead of white tile.

Besides containing 24 ward beds and their services, the fifth floor is equipped for a complete urological service, consisting of a doctor's office and dressing-room and a double cystoscopic room. The machine is mounted on a low dividing partition so that it can be used in either booth. Across the corridor is a receiving and waiting room, as well as a developing room.



FIFTH FLOOR PLAN



FIRST FLOOR PLAN

Left: The northern section of the first floor houses a tea-room, lunch counter and gift shop for the convenience of visitors, and the admitting and consultation offices. At the south end are doctors' offices and examining room, the superintendent's office and the purchasing department.

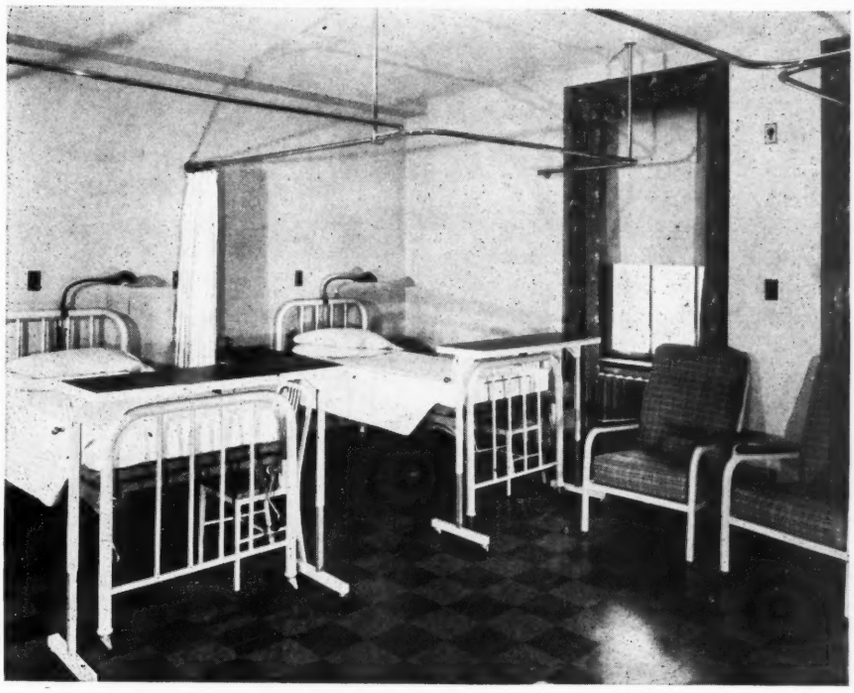
ceilings which are finished with acoustic plaster.

The stair halls are lined with buff, salt-glazed terra cotta blocks. Stairs are iron with cement treads and platforms. Color, hardener and abrasive are worked into the wearing surfaces. There are no newels, and handrails are warped continuously from the first to the ninth floors.

The main entrance lobby is colorful with warm toned burgundy-veined marble wainscot and trim. The floor is of terrazzo with a predominance of red and gold marble chips and the base and border are of green marble. The lobby and tearoom are equipped with fluorescent lighting to add to the cheerful decorative atmosphere of the entrance. The soda fountain is black trimmed with Chinese red and cream color. Table tops and stool seats are gay Chinese red to match.

There are two passenger elevators and one service elevator opening from lobbies off the main corridors. They are of the latest gearless type, with a self-leveling mechanism and power-operated hatch and car doors. They are finished in warm green enamel with stainless steel trim. Lighting and ventilating fan units are combined in a modern ceiling fixture in each elevator car.

Nurses' stations control both the elevator lobby and the main corridor. Each patients' floor has a medicine room, flower room and telephone booth. Outlets for private telephone connections are installed in each room.



All ward beds are separated from each other by curtains hung on rods suspended from the ceiling. Green curtains were selected as being more cheerful than white but owing to lack of materials only one floor has green curtains; the rest of the curtains had to be white after all.

Toilets, baths, pantries, treatment and utility rooms have buff tile floors, bases and wainscots. All pantries and utility rooms have acoustical ceilings. On the patients' floors the pantry opens off the service elevator alcove so that food trucks brought up from the main kitchen are kept out of the corridors.

Each main utility room has a dwarf partition separating it into two parts, one side for clean work and the other for soiled. The area in which the soiled work is done contains a bedpan washer, sterilizer and flushing rim sink, a bedpan warmer, a deep soaking sink with drainboard, a laundry chute, an airing cabinet and a stainless steel work counter with cupboards below and glazed dresser above.

One of the main utility rooms showing the section in which "soiled" work is done. This area, which is divided from the clean section by a dwarf partition, contains a bedpan washer, sterilizer and flushing rim sink, soaking sink and laundry chute.

The other half, where clean work is done, is equipped with water, instrument and utensil sterilizers, a blanket and solution warmer, a soaking sink, a supply closet and a stainless steel work counter and gas plate with ice chest below and a glazed dresser above. Both parts of the utility room have marble shelves. On the second and fourth floors there are additional subutility rooms to serve isolated, semiprivate patients' rooms separated from the other rooms by the elevator lobby and nurses' station.

As the new building extends from Sixth Street through to Seventh

Street it divides the existing hospital buildings, entirely cutting off the administration, ward buildings and power plant from the maternity, x-ray, laboratory and laundry buildings. This created two problems: the maintenance of circulation and the maintenance of services.

To keep traffic lanes open throughout all the hospital buildings during construction of the new pavilion an insulated, temporary corridor was built completely outside at the south end of the new building, running from the original administration corridor to the maternity corridor. This passage was lighted, heated and maintained throughout the course of construction.

The second problem was a combination of maintaining, altering and relocating existing services. Fortunately, when the original three buildings were constructed more than 50 years ago, they were connected by a pipe tunnel. Since then, as the hospital expanded and modernized its services, high-pressure steam and refrigeration lines, electric light and power and fire alarm were added. Unfortunately, however, as capacities had to be enlarged, existing facilities were continued and simply added to, instead of being replaced with larger lines, until the tunnel was choked with many small pipes. While the Buckley Pavilion was under construction room had to be made in the tunnel for the increased loads at the same time that all services to other buildings were maintained.

Electric conduits were run under the floor of the tunnel so that the present cables, the insulation of which had been burned by their proximity to the heating pipes, could be removed. Many existing high-pressure steam pipes were taken out, after fifty years of service in some cases, and a single header and auxiliary lines with their returns were installed. This procedure was carried out also for low-pressure and medium-pressure pipes, so that when the rerouting was completed the tunnel was carrying almost double its former load, with space to spare.

The total cost of the pavilion was $867,000, with a cost per cubic foot of 84¼ cents. The approximate cost per bed was $6000.

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Hospitals DO

LAST month's article told of instances of hospital cooperation "beyond the line of duty" with Blue Cross plans in Alabama, Pittsburgh, Massachusetts and San Francisco.

Before continuing the recital of specific instances, it might be well to point out that a few types of cooperation are mentioned by many Blue Cross plans. To avoid tiresome repetition, these will be summarized here.

Many hospitals apparently ask all patients if they are members of the Blue Cross plan. This has two results, according to Louis H. Pink, president of the Associated Hospital Service of New York. First, it protects the hospital in its collection efforts and, second, it keeps the name of the plan before the hospitalized public. This cooperation was also mentioned by the plans in Richmond, Va., Colorado, Des Moines, Iowa, St. Louis and Massachusetts.

Hospitals Extend Extra Benefits

Mr. Pink states that "although the contract with subscribers contains certain limitations and exclusions, many member hospitals go beyond the letter of the contract in extending benefits for services excluded. This obviously is responsible in a large measure for the feeling of confidence and good will in the minds of subscribers."

The plans in Colorado and New Orleans mention that some of their hospitals put Blue Cross members in private rooms without extra charge when all semiprivate facilities are full. The subscribers must be ready to move to semiprivate facilities when they are available, of course.

"Probably the most important and valuable action by our member hospitals in support of the Blue Cross movement," says Mr. Pink, "is their willingness to extend credit to subscriber-patients, thereby eliminating the necessity for cash outlay. All of our member hospitals are more than cooperative in that direction."

Furthermore, hospitals in Colorado, New Orleans, St. Louis, Philadelphia and many other places refuse to accept competing contracts from commercial insurance companies and to give similar credit arrangements to their policyholders.

The systematic distribution by hospitals of Blue Cross literature was reported from Des Moines, Iowa, Jamestown, N. Y., Philadelphia and Toledo, Ohio. A separate leaflet has been prepared in Philadelphia for each hospital. On the front is a picture of the particular hospital with a statement that "The ..... Hospital Recommends. . . ." The two inside pages describe the plan while the fourth and final page gives a history and description of the hospital.

Blue Cross executives in Wilkes-Barre, Sioux City and Massachusetts think it worthy of special comment that their member hospitals keep them informed promptly of groups that might be enrolled in the plan.

In Youngstown, Ohio, and in Minnesota it was especially remarked that the hospital administrators have taken a broad range point of view regarding the matter of payment for service. They have not insisted on obtaining the "last pound of flesh."

"I have found that the majority of administrators and trustees is willing to sustain the possible loss of a few cents per day per patient in order to keep the plan progressing and solvent with the least amount of disturbance among the subscribers," Arthur M. Calvin, executive director of the Minnesota Hospital Service Association, reports.

"I hesitate to mention any specific individual or hospital," says Mr. Calvin, "because there are many others I might omit who are doing fine jobs for us. One administrator, when he finds a Blue Cross subscriber being hospitalized longer than necessary, calls the matter to the attention of the physician. In other instances, administrators have called such cases to our attention. What we do about them is another story.

"Particularly in the smaller communities throughout the state, many of the hospital administrators are

Cooperate

To Make Blue Cross Plans "Click"

giving much of their time in arranging meetings of employed groups and spreading information regarding the plan in their community. I am amazed when I realize the amount of time and energy that is spent by hospital administrators on our board, on committees and on special work. They feel that the plan is their very own."

A high degree of loyalty to Blue Cross has also been evidenced in Philadelphia, according to E. A. van Steenwyk, executive director of the plan. "Two competing plans, one of them nonapproved, actually pay more money to member hospitals but have not been able to obtain member hospital contracts.

"Hospitals distribute literature, display posters and cooperate in other ways. Thus, for instance, x-ray service, anesthesia when provided by a medical anesthetist and laboratory service would not have been available to our subscribers because medical services are involved, but the hospitals by agreeing to repay physicians out of the payments made to them have made these services available to subscribers.

Cooperate in Spite of Drawbacks

"The device we have worked out with full hospital cooperation has certain disadvantages to the hospitals to which they would not have agreed except for their desire to cooperate fully with the people of our community.

"Hospitals in Philadelphia," Mr. van Steenwyk continues, "have recently altered the tradition-encrusted definition of semiprivate facilities so that Blue Cross subscribers are assured of facilities in rooms of from two to six beds. This sounds like a meaningless gesture, but it isn't, because until Blue Cross came to Philadelphia many 'semiprivate' rooms had from eight to 20 beds in them.

"Recently, about half of our member hospitals cooperated in the establishment of a ward plan. This also called for revision of some pretty fundamental concepts of serving ward patients. While no great number of subscribers has been enrolled under the ward plan, it is an anchor to windward which will eventually result in a significant service to the community.

"As vice chairman of the Council of Social Agencies it is possible for me to see how other agencies have pitched in to aid our program."

Administrators Aid Enrollment

The cooperation of three officials of St. Joseph's Hospital, Omaha, Neb., namely, Mother Mary Basila, provincial Superior of the Poor Sisters of St. Francis; Sister Mary Fulgentia Frisch, former superintendent of the hospital, and F. J. Bath, business manager, resulted in enrolling four other hospitals of the same order in the Associated Hospital Service of Nebraska, according to J. H. Pfeiffer, executive director.

"Without hospital cooperation, I do not think the Blue Cross movement would be possible," writes D. Lane Tynes of Community Hospital Service, Louisville, Ky. The Louisville member hospitals and the Community Chest raised $15,000 as original capital and the administrators "have served long and faithfully on our board.

"Arden E. Hardgrove of Norton Infirmary has been an important factor in the development of the plan, not only locally but nationally. H. L. Dobbs of Kentucky Baptist Hospital has made numerous addresses in our behalf, both to public gatherings and over the radio. H. A. Cross, formerly of Jewish Hospital, has taken a prominent part in our contemplated state-wide expansion and has given freely of his time and efforts.

"Sisters Edigna, Michaella and Ludovica of St. Anthony's, St. Joseph's and SS. Mary and Elizabeth hospitals, although they have not appeared so prominently before the public, have always backed the plan to the limit."

Ralph Jordan of the Central Hospital Service, Columbus, Ohio, says that "all of our hospitals have given excellent cooperation. We appreciate their efforts especially in three phases of their service.

"First, our hospitals are creating an excellent impression with Blue Cross subscribers by reducing red tape to a minimum upon their admittance. Our subscribers are taken directly to their rooms at the mere mention of Central Hospital Service.

"Second, all of our hospitals and doctors are giving fine cooperation in admitting and discharging patients when rooms are scarce. We really believe that our subscribers are given preferred attention although it is not our intention to ask hospitals to discriminate between our cases and other meritorious cases. We do, however, feel grateful for the special consideration and attention given our people.

"Third, during this period when maternity cases are numerous, the hospitals have cooperated by reducing the stay to about five days."

There Are Some Skeptics

Not all hospitals, of course, cooperate. One plan director states that "frankly, I can think of nothing that our hospitals have done to assist us in placing the Blue Cross plans before the public. We have attempted to keep leaflets in the foyers of hospitals. We go back to the hospital to find that the literature is still there, behind some desk or file."

The contrast in attitude among hospital administrators is illustrated by a statement by Leon R. Wheeler of Associated Hospital Service of Wisconsin. "One city in this state has two hospitals. The administrator of one is entirely indifferent to the plan. His attitude has been that he would not promote the plan because he wanted no responsibility for any complaints that might arise.

"The superintendent of the other hospital is just the opposite. The finest of cooperation has been shown at all times; he even makes calls with our representatives and has addressed meetings of interested groups when our representative was not available.

"The results are that the first hospital has received from the plan approximately half of the income per bed that the other hospital has received. The disinterested hospital, however, has recently seen the light and is now more responsive.

"Sister M. Laetitia, superintendent of St. Joseph's Hospital, Beaver Dam, has done an outstanding job in public relations regarding both the Blue Cross plan and her hospital, even though it is a new hospital and the Sister has been in the community only a short time. She knows the key people in the community and her interest in community affairs has established her as one of the city's leaders. Accordingly, she is in a position to make her recommendation of the Blue Cross extremely effective."

Some fine cooperation in Colorado is pointed out by William S. McNary, executive director of the statewide plan. In May he wrote that "we are at present engaged in enrolling the employes of a large Denver manufacturing concern which should increase our total participants by some 4000 persons.

Refuse Commercial Contracts

"This concern has for years contracted for the care of its employes at one of our member hospitals. The growth of the Blue Cross plan brought about a demand from these employes for the protection of their families. Representatives of management got in touch with the contracting hospital to make an arrangement for families but were urged by this hospital (a Catholic institution) to make the Blue Cross available. Extension of the contract was refused.

"The management representatives then attempted to make such an arrangement with each of the other major hospitals in Denver but were met with the same suggestion at each. We felt this was a fine demonstration of the cooperative spirit of the hospitals.

"We have two small member hospitals, Colorado Hospital and St. Thomas More Hospital, in Canon City, which is a town of about 5000 persons serving an area with a total population of not more than 10,000 or 12,000. Linnie Wilkinson, owner of Colorado Hospital, has evidenced outstanding interest in the development of the plan in her community. She has made hundreds of phone calls and dozens of trips arranging meetings for our representatives and urging enrollment.

"Both Miss Wilkinson and Sister M. Luitgard, the Superior of St. Thomas More, have made arrangements to accept Blue Cross payments, since we have no branch office in Canon City. They have been instrumental in enrolling some 3000 participants.

Little Competition in Denver

"Except in isolated instances, the Blue Cross is not troubled by competition of any kind in Denver. One of the reasons for this is the attitude taken by our hospitals in their relations with patients, which, in general, is that commercial policyholders are told that their patronage is welcomed but that credit is not extended on the basis of their insurance protection inasmuch as payment is due the policyholder and not the hospital.

"In most instances the hospital advises the patient that the Blue Cross card is the only one acceptable as a credit card. All hospitals have agreed from the start to refrain from making any new industrial contracts. All hospitals make a special effort to provide accommodations for our patients."

In Iowa, the three Des Moines hospitals use a bill for nonplan members that shows the actual amount that the patient must pay and the amount that would have been paid for him had he been a member of the Blue Cross. At the bottom it states: "Blue Cross would have paid all items in the right hand column if you had been a member . . . you would have been home sooner, back on the job quicker. For further information about Blue Cross, ask this hospital."

Other parts of the statement give further information about the plan. E. P. Lichty reports that this statement has interested a large number of people in joining the plan. Especially fine cooperation has been given by Iowa Methodist Hospital where the entire bookkeeping personnel is enthusiastic about the plan.

In Quincy, Ill., the administrator of one hospital persuaded prominent business men to sponsor a full page advertisement giving information about the Central Illinois Hospital Service Association.

Louisiana hospitals absorbed an operating loss of $14,000 incurred by the Hospital Service Association of New Orleans in its first two years of operation. The six leading hospitals in New Orleans published a joint statement in the newspapers reading as follows: "Only contracts of the Hospital Service Association of New Orleans are acceptable to the undersigned hospitals in lieu of cash payment upon entrance for service."

Robert E. Mills of the Youngstown, Ohio, plan states that his member hospitals "have uniformly refrained from asking for more money for hospital care of our subscribers and have cooperated in every way to fulfill the terms and obligations of the contract. David Endres of the Youngstown Hospital Association has been particularly active in putting this point of view across."

In Northeastern Pennsylvania, Howard Bishop of Robert Packer Hospital, Sayre, sent a member of his staff to several groups and enrolled them for the plan, according to George T. Bell, executive director, who also mentioned extra-routine assistance from Robert Gloman, Wilkes-Barre; Laura Ott, Waverly, N. Y.; Mrs. Hilda Mills, Towanda, and Sister Mary Paul, Wilkes-Barre.

Every hospital in Sioux City, Iowa, mailed out on its own letterhead an appropriate letter to all of the business houses with which it deals urging them to consider Blue Cross service for their employes, O. L. Smith of the Sioux City plan reports.

Blue Cross Must Continue to Grow

Although less than half of the plan directors sent in specific instances of hospital cooperation, undoubtedly those who did not reply could have swelled the number of cases several times. Some hospital administrators still do not realize the close identity of interest between their hospitals and their Blue Cross plans. But more and more administrators and other staff members are going out of their way to do something beyond the contract so that the Blue Cross plan may grow and serve the people of the community more effectively. Larger enrollments are essential today if hospitals are to avoid federal control.

EVERETT W. JONES

Joins the Staff of The Modern Hospital

Photograph by George Nelidoff

IN ANTICIPATION of the expanded opportunities and obligations of the postwar period, The Modern Hospital Publishing Company announces that arrangements have been completed for Everett W. Jones to join the staff on November 1 as a vice president. He will for the present concentrate on problems involving The *Hospital Yearbook* and Latin-American publications.

Mr. Jones is head hospital consultant in the Governmental Division of the War Production Board. He is also administrator-on-leave of Albany Hospital, Albany, N. Y., where he has carried the title of director and assistant secretary of the board of governors. Mr. Jones has completed the organization of the hospital section in the Governmental Division of W.P.B. and is now able to relinquish his full-time duties. Maury Maverick, director of the division, has asked Mr. Jones to continue as a consultant on hospital problems on a part-time basis.

Mr. Jones is an engineer by training, having been given his B.S.E. by the University of Wisconsin in 1923. From 1917 to 1919 he was a member of the U. S. Army Medical Corps of the American Expeditionary Force, advancing from private to sergeant, first class. During the summers of 1921 and 1922 he was an engineer and inspector for the Wisconsin State Highway Commission. Following this he was an engineer in the development division of Western Electric Company in 1923 and 1924.

In the latter year he was appointed chief engineer of the John A. Manning Paper Company, Troy, N. Y. His work there was so outstanding that in 1926 he was advanced to general operating superintendent. In 1933 and 1934, Mr. Jones did a special piece of work in sales engineering and marketing geography for the Behr-Manning Corporation. This work was in addition to his regular work in the paper mill.

The late John A. Manning, president of the Behr-Manning Corporation and of the John A. Manning Paper Company, was made president of Albany Hospital in 1930 and asked Mr. Jones to study the mechanical and accounting departments of the hospital. Mr. Jones was Mr. Manning's consultant and adviser at the hospital until, in 1934, he went to the hospital on a full-time basis; he was appointed director in 1935.

At Albany Hospital, Mr. Jones raised the professional level of the institution, improved its personnel practices, strengthened its financial position and promoted a broad public relations program. Under his supervision, a $500,000 program of plant renovation and modernization was carried out.

He has been an active member of the regional, state and national hospital associations and of the American College of Hospital Administrators. He is one of the founders of the Associated Hospital Service of the Capitol District, the Albany Blue Cross plan, and served on its executive committee until going to Washington. He has also served as chairman of the Hospital Council of Albany and as president of the Northeastern New York Hospital Association.

Mr. Jones served for five years as chairman of the New York State Hospital Association committee on social welfare laws and his work was largely responsible for improved relations between hospitals and welfare commissioners and for increased rates of payment for the care of indigents in New York hospitals.

In the American Hospital Association, Mr. Jones has been active on many committees. He has been a member of the Latin-American committee since 1937 and has been an alternate in the A.H.A. house of delegates since 1941. He has been chairman of the pharmacy section and of the committee on purchasing, simplification and standardization, as well as a member of the committee on fuel economy, repairs and maintenance.

Mr. Jones brings to The Modern Hospital a thorough experience in engineering, manufacturing, industrial management and hospital administration.

Civilian Hospital Needs
IN THE POSTWAR DECADE

THREE BILLION DOLLARS IN NEW AND REPLACEMENT BUILDING WILL MEET NATIONAL HOSPITAL NEEDS

ALDEN B. MILLS and RUSSELL T. SANFORD

THE construction and rebuilding of civilian hospitals, both voluntary and governmental, in the postwar period is going to be a big business if the needs of the American people are to be met. This is apparent from a study just concluded by The MODERN HOSPITAL, using the latest authoritative data.

The accompanying table shows that from $300,000,000 to $450,000,000 per year must be spent for a decade to meet the country's civilian needs. These are minimum figures for several reasons.

1. They do not take into account the large additional needs for war veterans. Although no specific figures will now be officially released by the federal government, the number of beds required by the armed services and the Veterans Administration will undoubtedly expand greatly. Beds for veterans, which have recently been increased from 85,000 to 100,000, will probably be further increased to 250,000 or 300,000.

2. The need for convalescent care was tentatively estimated by the committee on administrative practice of the American Public Health Association some years ago at 75 beds per hundred thousand population and the need for chronic service at 200 beds per hundred thousand. In the 1943 register, the American Medical Association listed 9793 beds under "convalescent and rest" but because their number is so small the register did not list separately any beds in chronic disease hospitals.

Adequate provision for convalescent patients or those with chronic diseases would relieve somewhat the load on certain general hospitals.

The A.P.H.A. standards would, therefore, require about 89,000 more beds in convalescent institutions and about 263,000 beds in chronic disease hospitals. Even at a low figure of $1000 per bed, the filling of these needs would involve an investment of $350,000,000. Spread over a five year period this would add $70,000,000 per year to the hospital construction bill. If spread over ten years, it would involve $35,000,000 per year.

Because there is now no strongly organized effort to meet these important needs, the figures have not been included in the table.

3. Another omitted item is the construction of small health and diagnostic centers in rural areas. The federal government's Technical Committee on Medical Care stated in 1938 that "health and diagnostic centers are greatly needed in rural areas where they may serve as centers for the local health department staff, including visiting nurses, maternal and child welfare staff and basic laboratory and other diagnostic staff, for local physicians and for emergency beds.

"It may be conservatively estimated that about 500 such centers might properly and usefully be built in areas that are without local hospitals but, being adjacent to areas that have hospitals, can have the needs of their people and their physicians met by these centers."

The committee estimated the cost of such centers in 1938 prices at about $15,000,000. This figure does not appear in the table since such centers would not be strictly necessary if adequate hospitals are provided in small towns and rural areas.

4. The most important item to the general public is the addition of needed general hospital beds and the replacement in general hospitals of facilities that have become obsolete. The estimates shown in the table are based on the widely accepted standard of 4.5 beds per thousand population (urban and rural combined) as a reasonable minimum.

It is known, however, that states like Rhode Island, New Hampshire, Maryland, New York, Colorado, Massachusetts, California and the District of Columbia that have higher ratios than this also have occupancy that is higher than the national average. Of the 18 states with more than 4.5 beds per thousand in 1941, eight had occupancy at or above the national average. Of the 31 states with less than 4.5 beds, 19 used their facilities less than the average for the nation.

Apparently, therefore, 4.5 beds in general hospitals is not by any means a saturation point if the community has enough wealth to enable people to obtain hospital care when they need it. The growth of Blue Cross

1945-1955

plans is expanding the number of people who are able to pay. If there is direct federal or local government aid to assure the provision of minimum hospital needs, the effective demand will doubtless increase still more rapidly.

The estimate of 92,000 additional beds needed in general hospitals makes no allowance whatever for additional beds in the 18 states now having more than 4.5 beds per thousand population. Yet we know from previous experience that these states are quite likely to continue to add beds to meet the demands of their communities. And they include certain of the most populous states, *e.g.* New York, Massachusetts and California.

Furthermore, a detailed study of each specific area in the country would undoubtedly reveal certain areas in which there is an inadequate number of beds within reasonable distance of the people who need to use them. If 25 or 35 miles were taken as the maximum feasible service distance for general hospitals and 75 or 100 miles as the maximum for mental and tuberculosis institutions, the figures would need to be increased.

The continuing urbanization of our population increases the effective demand for service in general hospitals inasmuch as urban people use hospitals more extensively than do rural groups. A ratio of 7.5 per thousand for large cities will probably soon be standard.

The 11,000,000 or more men and

Postwar Civilian Hospital Needs

Type	Beds	Estimated Cost Per Bed	Total
New Construction Now Needed			
1. General and special hospitals	92,000	$6,000	$552,000,000
2. Tuberculosis hospitals	44,000	4,000	176,000,000
3. Nervous and mental hospitals	143,000	2,500	357,500,000
Total	279,000		$1,085,500,000
Replacement of Obsolete Facilities			
4. Normal annual replacement	33,125	$4,500	$ 149,063,000
5. Normal replacement deferred by war during 1942, 1943 and 1944	99,375	4,500	447,187,000
Total New Construction and Replacement on Five Year Basis			
6. Total postwar replacement need on 5 year basis	265,000	$4,500	$1,192,500,000
7. New construction needed	279,000		1,085,500,000
8. Total	544,000		2,278,000,000
9. Annual Rate	108,800		455,600,000
Total New Construction and Replacement on Ten Year Basis			
10. Total postwar replacement needed on 10 year basis	430,600	$4,500	$1,937,700,000
11. New construction needed	279,000		1,085,500,000
12. Total	709,600		3,023,200,000
13. Annual Rate	69,260		302,320,000

NOTES TO TABLE:

Line 1. The number of general hospital beds needed was computed for each state by multiplying the 1940 population of the state by the extent to which the 1941 ratio of general hospital beds fell below 4.5 per thousand. This ratio appears in the Journal of the American Medical Association for March 28, 1942, on page 1055. Similar ratios were not computed by the A.M.A. for 1942. The large increase of beds in temporary general hospitals of the armed forces would make 1942 ratios inaccurate for present purposes.

The estimated cost per bed is based on figures in "The Public's Investment in Hospitals" by C. Rufus Rorem (University of Chicago Press, 1930) showing that governmental general hospitals in 1928 cost $3600 per bed and nongovernmental general hospitals cost $5600. The weighted average of these was $4900. A recent report by F. H. Dow of Dow Service, appraisal experts, stated that brick and concrete hotels increased 21 per cent in construction cost from 1929 to 1943 and brick and steel structures increased 24 per cent. Hospitals, having even more complicated equipment and constantly expanding in functions, probably increased in cost even more. To be conservative a 1943 value of $6000 was assumed.

Line 2. The federal Technical Committee on Medical Care estimated in 1938 that 50,000 additional beds for tuberculosis were needed to bring existing facilities up to the accepted standard of two beds per tuberculosis death. Since 1938 there has been a net increase of 6000 beds in tuberculosis hospitals. So, even disregarding the increase in population, the net remaining deficiency is 44,000.

Rorem's figures showed an investment per bed of $3100 in tuberculosis hospitals in 1938. Corrected by the Dow percentage mentioned above this becomes $4000 in round numbers.

Line 3. The Technical Committee on Medical Care stated that the accepted ratio of nervous and mental hospital beds per 1000 persons is 5.6. Computing the figures separately for each state gave total needs today of 143,000 additional beds.

Rorem's investment figure for 1928 was $2100 per bed for nervous and mental hospitals. Increased by 24 per cent, this becomes $2500 in round figures.

Line 4. Normal replacement is computed at 2½ per cent of the 1,324,381 beds in all registered hospitals in 1941. (Figures for 1941 were chosen so as to omit the large growth of federal hospitals in 1942.) The average investment in all hospitals in 1928 was, according to Rorem, $3500; this was increased to $4500 to reflect changed building costs and increased facilities.

Line 5. It is estimated that the equivalent of three years of normal replacement of hospital facilities will be deferred by the limitations imposed by the war. In many instances hospitals actually have the money available now for such modernization or replacement but are deterred by actual or expected W.P.B. disapproval.

Line 6. This is the sum of five times line 4 plus line 5.

Line 9. This is the average annual hospital construction rate and costs if present major deficiencies are made up within a five year period following the close of the war.

Line 13. This is the average annual hospital construction rate and costs if deficiencies are made up during a ten year period. It is only about 15 to 20 per cent higher than "normal" hospital construction.

women in the armed forces are becoming accustomed to a complete and efficient medical and hospital service. They will doubtless wish a similar service for themselves and their families.

Improved methods of treatment, such as sulfa drugs for pneumonia, seem to increase rather than decrease the demand for hospital services. Such methods save lives but they are best administered in a hospital.

Need More Tuberculosis Beds

5. The estimated need for tuberculosis beds takes no account of population increases or of any increase in the incidence of this disease resulting from the war. The steady decrease in tuberculosis deaths, if it continues, will help to make it possible for construction to catch up with minimum standards. One authority, however, believes that the standard might well be raised to 2.5 beds per death instead of the generally accepted 2 beds.

6. For mental hospitals, also, the estimates are minimal. No account is taken of the geographical location of such hospitals within the boundaries of the various states. Nor is any special consideration given to the well-established need for additional facilities for the care in general hospitals of patients with mental disease.

7. The estimated costs per bed are based on the exhaustive study by C. Rufus Rorem, "The Public's Investment in Hospitals." Partial corrections have been made for the differences in construction costs between the time he made his study in 1928 and the present day. If wage rates remain near their present levels, however, the cost of building materials and building labor will make these figures too low. No correction has been made, moreover, to take account of the substantial increase in the complexity of hospital service and equipment in this fifteen year period, which will doubtless more than absorb any economies in hospital construction that may be effected.

8. The 1940 census figures have been used for population. There have been some increase and tremendous movement of the population during the last three years. Such movement inevitably swells the need for hospital service because the new "boom towns" find their facilities greatly overcrowded and are not helped by the fact that there may be partially used facilities in the communities that the migrants have left. Some of the migrants will return to their former homes when the war is over but large numbers of them will stay in the new communities.

Furthermore, the population will probably continue to increase during the war and the five or ten years following. It has been estimated that the average annual growth of population during the present decade will be from 800,000 to 1,000,000 per annum. By 1950, therefore, the population will probably be from 8,000,000 to 10,000,000 larger than it was in 1940 and facilities will need to be provided for these persons.

9. The normal annual replacement of obsolescent or obsolete facilities has been computed on the basis of a forty year life for existing structures. While many hospital buildings are still serving after considerably more than forty years, this is a well-accepted and conservative figure. Some hospital administrators have stated that even this period witnesses such striking changes in the nature and need for hospitalization that buildings should either be torn down or completely rebuilt on the inside at more frequent intervals.

10. A great deal of hospital construction is done in normal times without increasing the bed capacity of the hospital. This includes housing and educational facilities for interns, residents, nurses, dietitians, technicians and others, new surgical and delivery suites, power plants, laundries, central supply rooms, storerooms, pharmacies, out-patient departments, radiologic and pathologic laboratories, offices, physical therapy and occupational therapy departments, libraries, kitchens and cafeterias and, in nervous and mental hospitals, such facilities as garages, warehouses, dairy barns and other farm buildings.

There will probably be a substantially increased demand for office accommodations for practicing physicians so that they can centralize their work in or adjacent to hospitals.

No specific estimates of such types of construction or modernization are included although the cost per bed figure used is designed to include some share of these professional and service areas.

It is readily apparent, therefore, that these figures, although large in the aggregate, represent only minimum needs. Whether these needs will actually be met in the five or ten years following the close of the war will depend upon the financial strength of the voluntary hospitals and their supporters and the extent to which federal, state, county and city governments are willing to provide funds to meet their particular responsibilities. These factors, in turn, depend in considerable part upon the general economic condition of the country.

There are certain indications that at least part of this need will be met. Voluntary hospitals, for their part, are now preparing floor plans and soliciting funds to be ready to build as soon as materials and labor are available. Two examples are the Women's Hospital of Flint, Mich., which recently raised $1,113,000 in a campaign for $1,000,000, and the Hartford Hospital, Hartford, Conn., which raised more than $5,000,000.

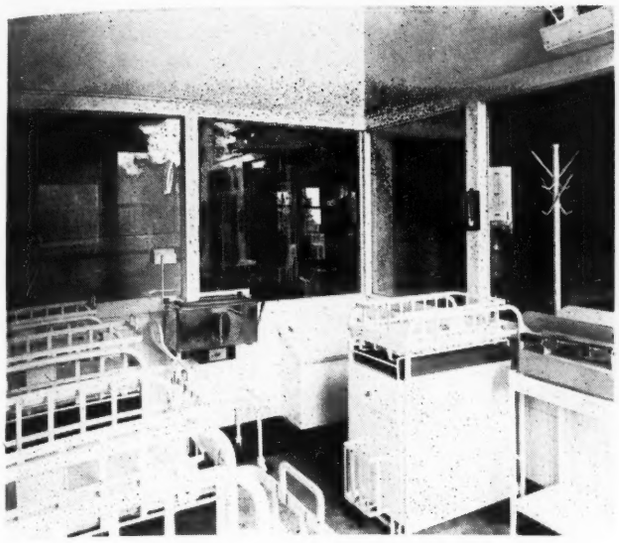
Federal Funds Sought

Several bills have been introduced in Congress in recent years to provide federal funds to aid in the construction of governmental and voluntary general hospitals that are needed in areas that cannot raise sufficient funds to build their own. President Roosevelt has indicated his strong support of such measures.

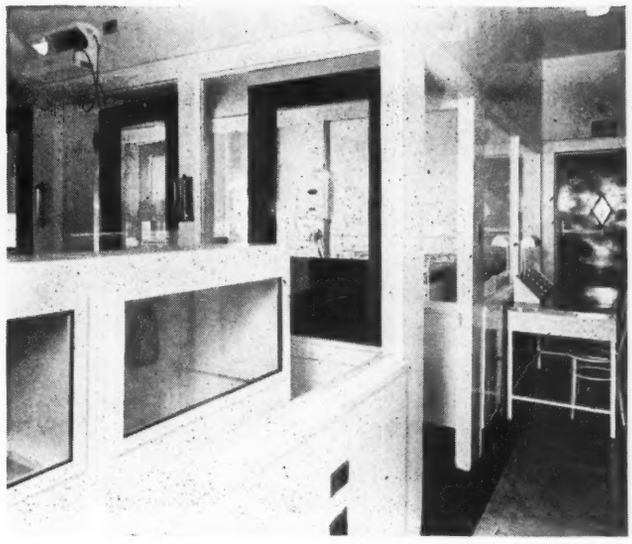
Because they will make one of the best possible types of postwar public works projects, it seems probable that part of the funds needed for the construction of such hospitals will be provided by the federal government. Precedent for government loans and grants to nonprofit hospitals was set by the Lanham Act.

Many of the states were already engaged in programs of rebuilding and extending their state hospitals for nervous and mental disease cases when war brought these programs to a sudden stop. Most of the states are now building up cash reserves and will be in a position to resume their hospital building programs when the war ends. The same applies to state tuberculosis hospitals and to those under county ownership.

In spite of all of these facts, of course, one has no definite assurance that hospital construction will follow the estimates set forth. But the estimates are suggestive as showing the general extent of the problem and the probable course of its solution.



Room for feeding problems, with individual bassinets, sterilizer and ultraviolet light. Waste is removed from this room through disposal box at right of sterilizer.

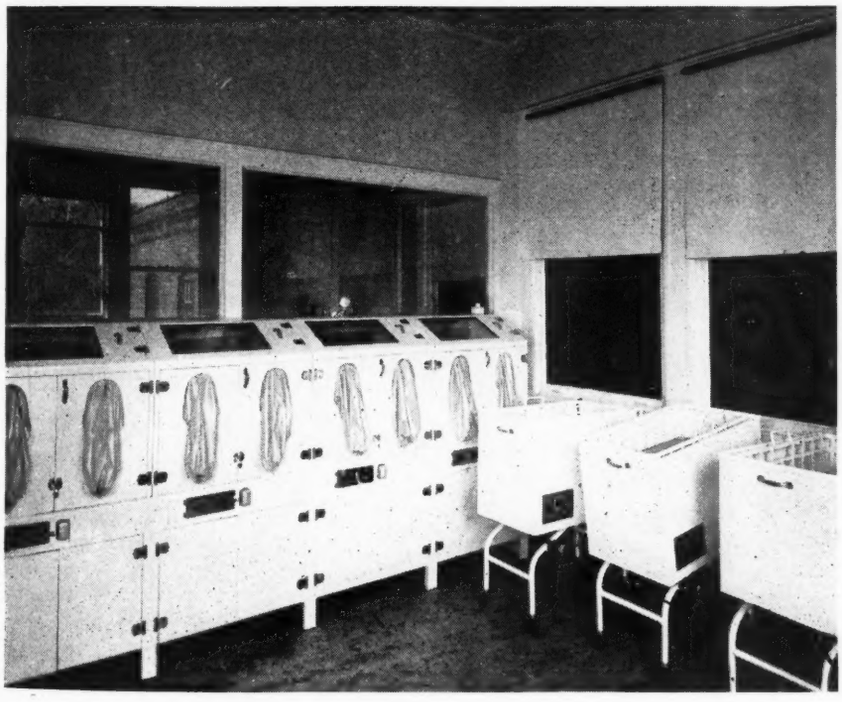


Visitors' corridor. Door at right leading into children's ward is protected by an ultraviolet light barrier. The center hall is the doctors' gowning room.

Protection for Premature Infants

FRANK B. GAIL
Manager
West Jersey Homeopathic Hospital
Camden, N. J.

SEVERAL years ago when the pediatric department of West Jersey Homeopathic Hospital, Camden, N. J., took over the care of all new-born infants the need for an adequate premature unit was realized. Investigations of existing premature installations were started and eminent specialists were consulted. The new nursery that resulted is a complete and efficient layout.



Four incubators and three hot beds for graduate prematures. Each incubator is individually controlled as to temperature and humidity.

The room now occupied was formerly a solarium adjoining the children's medical ward. It has a south and east exposure—seven windows on the south side and three on the east. From the children's ward a door opens into a corridor running the entire length of the room.

Visitors, properly gowned, are admitted to the hall and can view the babies through the glass partitions and the glass backs of the incubators. Over the doorway a 36 inch ultraviolet light with a slot cut in the bottom of the fixture radiates rays downward and acts as a barrier to any air-borne bacteria passing from the ward. A similar unit is placed at the end of the corridor to radiate the end of the hall where visitors usually congregate. A nurses' chart desk occupies one end of this hall.

The hall is divided equally by a center corridor forming two rooms of equal size on either side. On the left is the premature room and on the right is a room equipped to care for infant feeding cases. The front part of this center hall is equipped as a washing and gowning room for the nurses and physicians entering the unit. The rear is further divided and contains an examining table and a clean linen storage cabinet.

Specialists Are NOT *Exploited*

Doctor MacLean Speaks Up for Hospitals in the Case of A.M.A. v. A.H.A.

LT. COL. BASIL C. MACLEAN

Director-on-Leave
Strong Memorial Hospital
Rochester, N. Y.

Foreword

In view of the recent adoption by the house of delegates of the American Medical Association of a resolution condemning hospitals for the "practice of medicine," the following article is especially timely. It was originally presented at a meeting of the American College of Surgeons in October 1939.—ED.

ANYONE who speaks up in defense of hospitals at this time and in the presence of organized medical groups is likely to be classed as a devil's advocate. The hospital is blamed for many sins and credited with few virtues by certain articulate professional groups. Fortunately, the public does not share this distrust but appears rather to applaud the efforts of hospitals to make hospital service more available and more budgetable.

Principles Are Agreed Upon

Apparently there is no quarrel with the principles of relationship as agreed upon by the representatives of the hospitals, the anesthetists, radiologists and pathologists and published in 1939 by the Council on Professional Practice of the American Hospital Association, but there persists a question of interpretation of the agreement relative to exploitation.

I admit that there have been and are instances in which revenue from departments of radiology and anesthesia exceeds the costs of these departments and in which salaries to professional personnel are too low. When the professional personnel is generously paid, however, there should be no rift in relationship unless facilities and equipment are inadequate or unless charges to the patient are too high.

It surely is evident from the expressed opinions of the profession and from the attitude of the public that it is considered socially and economically desirable in hospital care to make up a little on the departmental apples what is lost on the day rate oranges.

For theorists to clamor for a cost basis charge in each and all of the services of a hospital is idle. In many hospitals, the charges for x-ray service are too high, but it may safely be predicted that a lowering of fees in the x-ray departments of nonprofit hospitals would draw an immediate fire of criticism from independent roentgenologists.

Furthermore, the establishment of a system by which the hospital would render and charge for only a technical service would undoubtedly result in the roentgenological interpretation's being done, in many instances, by the attending physician and without consultation with a roentgenologist. This surely would not, in the long run, be for the good of the patient.

I hold no brief for the institution in which there is real exploitation of the staff or of the patients and I am quick to denounce the hospital that hides petty larcency under a cloak of charity. I do defend, however, the full-time salary system of recompense in hospital departments of x-ray, anesthesia and pathology that obtains in most of the better hospitals of the United States.

The improvement of the diagnostic aids and technical services of a medical nature in these departments of hospitals during the last thirty years has been one of the most important factors in the conversion of hotels for the sick to scientific institutions. Many outstanding physicians are associated with such departments and, regardless of system of remuneration, enjoy as much esteem, privilege and dignity as their colleagues in the purely clinical branches. The monetary rewards, indeed, usually exceed, on the average, those of their clinical fellows.

The wide use of a flat rate for laboratory work in hospitals and the extension of the principle of all-inclusive rates for hospital care are indications of the efficiency and desirability of these methods of making good hospital care available to the public. Some agitation obviously is prompted by a delusion that professional ability and dignity depend upon method of recompense.

Distinguished physicians in these hospital departments are quick to deny that one cubit could be added to their professional stature by transfer to a piecework system of payment. As Goldwater has warned: "The development of intolerable conditions under a multiple fee system would give enormous impetus to the demand for state control of hospital medical practice. A distinction should be seen between the practice of medicine and transactions of a purely business nature which are incidental to, but not of it."

Trend Is Toward Coordination

It is unnecessary to discuss the complexities and involvements of clinic and free services or of teaching facilities in respect to the organization of such departments. Certainly, the use of the departments of x-ray, bacteriology and pathology may be considered in the realm of public health. I do not believe the analogy to surgical practice is a true one, but even in the sacrosanct realm of surgery the trend is obviously to-

ward coordination between hospital and doctor in all things that pertain to the best interest of and the care rendered to the patient.

I am frank to admit that I believe in the principle of all-inclusive rates as instituted and developed so successfully by a number of leading hospitals. I believe also that hospital insurance coverage through nonprofit hospital service plans should be as inclusive as possible in hospital care within the bounds of soundness and safety. Failing this, I fear that the voluntary system will fail to avert a compulsory or governmental system in this country.

In Goldwater's masterly article "Medical Practice and Hospitalization," he said: "To the distinction between medical practice and business transactions incidental to it must be added the distinction between the practice of medicine and technical aids to medical practice."

Where there is abuse, he believed that the remedy "lies in a more equitable business arrangement, not in the destruction of types of hospital organization that have been developed in response to the demands of the medical profession itself and in deference to felt social needs."

No one has better stated the case than he when he said: "If hospital administrators believe, as I do, that the direct payment of a separate medical fee to every physician contributing directly or indirectly to diagnosis or treatment would diminish hospital efficiency, would obstruct adequate medical care and would embarrass physicians who are primarily responsible for treatment and on whom patients directly depend, they not only have the right to oppose but are under moral obligation to combat the multiple fee system.

"Responsibility for making hospital care adequate is not the responsibility of the trustees or lay branch of hospital administration alone; it is equally the responsibility of hospital medical staffs and of the medical profession.

"Hospitals do not, hospitals cannot practice medicine; hospitals can and must participate in the organization and business-like administration of hospital medical practice in order to meet the demands of their visiting staffs and fulfill their obligation to provide adequate hospital care. It is inconceivable that an intelligent medical profession will refuse to cooperate with hospitals that are eager to serve the public and that propose to do so in a manner which rigidly excludes profiteering and which is not only acceptable to but actually responsive to the needs of their staff members."

WOMEN'S SERVICE GROUPS

Sew and Eat Pie!

As old as the hospital itself is the women's auxiliary at Everett General Hospital, Everett, Wash. Its chief benefaction is the benevolent bed fund for children. It is through the auxiliary that the various church groups come one day a month to the hospital for sewing. They bring their own sandwiches and the hospital furnishes the beverage and pie. And such pie as the hospital's famous pastry cook—a woman well into her sixties—does bake! And don't think that the pie doesn't stimulate, along with the gastric juices, a well-disposed attitude toward the hospital and its charitable ventures.

Volunteer in Braille

Most rewarding of volunteer services must be that in the Braille department at such institutions as Wills Hospital, Philadelphia. This hospital, popularly known as "Wills Eye," is proud of the special honor recently paid Gray Lady Mrs. Joseph A. McKeon when the local chapter of the Red Cross awarded her the Ten Year Service pin.

If Mrs. McKeon's plans worked out, a class in Braille for volunteers started in September. This class should supply an adequate number of teachers of Braille to help patients during that critical time when they realize that vision cannot be restored.

Money Flows in Ohio

An Ohio device for raising money for hospitals and other charities is the collection of tax stamps of all denominations. For instance, the Mercy Hospital Stamp League in Hamilton, Ohio, has netted the hospital $8000 worth of equipment in the last four years, much of which is now irreplaceable.

Here is what these women's efforts have purchased: resuscitator, carriage and table, radio system, infants' scales, emergency light, two sterilizers, fracture bed, gauze cutter, anesthesia machine, meat cutter, stencil duplicator, incubator, obstetric table, other smaller items and, in addition, $700 worth of war bonds.

With no new automobiles, washing machines or refrigerators, sales tax stamps are now not as plentiful as they were, but Mrs. Mina Clawson, the treasurer, keeps the women's morale high and the money flows in.

Stars and Bars

Historic Pennslyvania Hospital, Philadelphia, held its 192d annual meeting recently and one of the new events in the time-honored order of business was the awarding of service bars to volunteers.

The bars are in the form of military service ribbons, blue and gray for 100 hours of service, with the addition of one red star for from 200 to 400 hours, two stars for from 400 to 1000 hours and three stars for 1000 or more hours. Five women now wear the three stars.

"Double Duty Dollars"

Presbyterian Hospital and its women's board are 60 years old and the anniversary is being celebrated with something more than a formal tea and photographs in the newspapers.

A charter member of the women's board and its honorary president, Mrs. David W. Graham, had the idea of aiding the war effort and the hospital as well by raising a new fund for the endowment of maternity beds, asking that contributions be made entirely in war bonds and stamps.

The goal is $25,000 and the "double duty dollars" are pouring in. There is no thought that the quota will not be met for there is precedent behind such a drive. Ten years ago, on the occasion of the fiftieth anniversary, the board raised a $25,000 endowment fund for the school of nursing.

Like most hospitals in 1943, Chicago's Presbyterian needs that maternity endowment badly for so far this year births in this hospital have increased 20 per cent over the same period of last year.

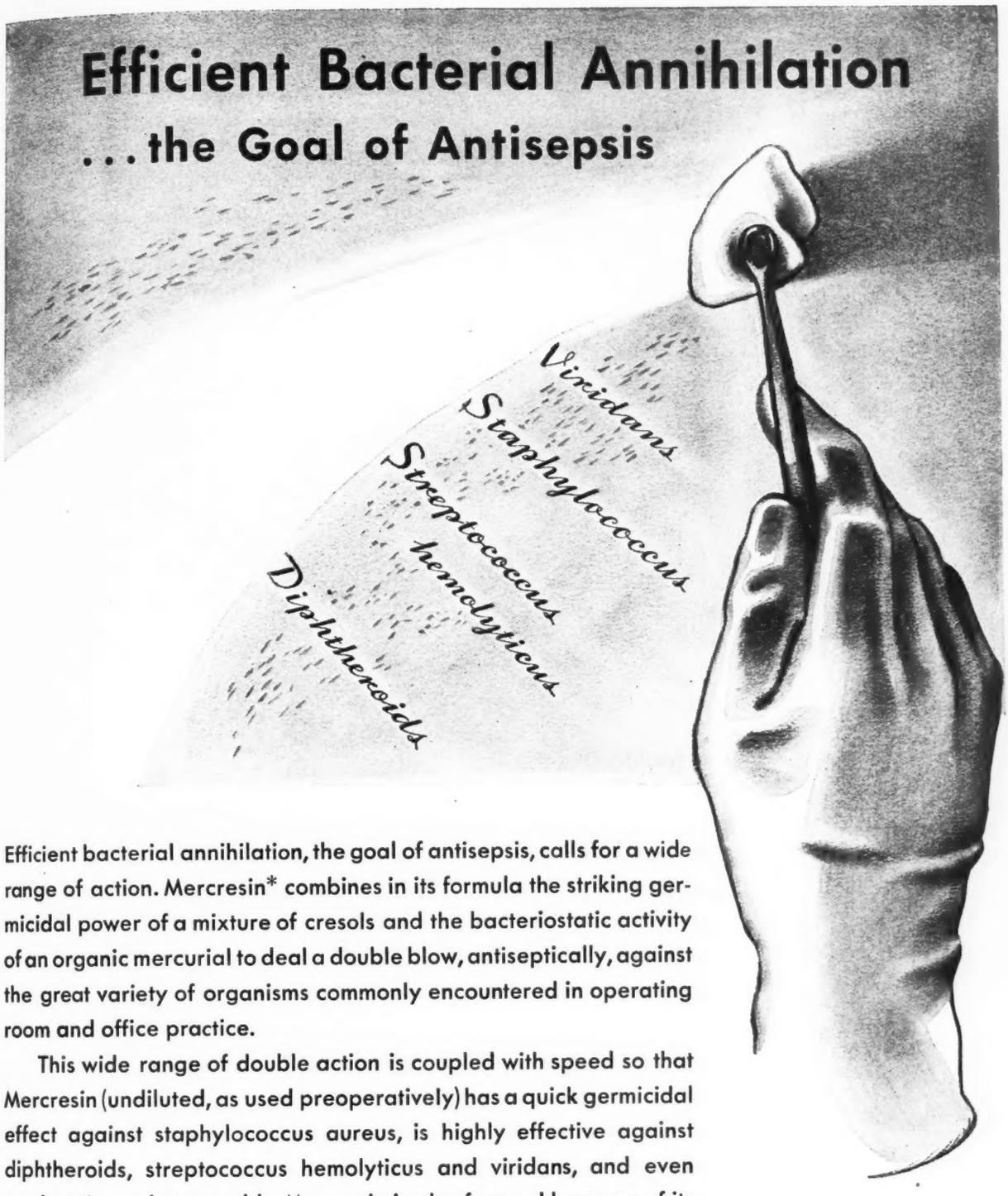
The Vachs

In Wisconsin they call them Vachs (volunteer assistants in clinics and hospitals) and the first class of 150 has recently been graduated from an orientation course given at the Milwaukee Vocational School under the sponsorship of the civilian defense office.

The course consists of six lessons, each one hour long, and is open to persons who have completed two years of high school work or its equivalent.

A central clearing office has been established and candidates list with it their choice of jobs and their available hours for volunteer service.

Efficient Bacterial Annihilation
...the Goal of Antisepsis



Efficient bacterial annihilation, the goal of antisepsis, calls for a wide range of action. Mercresin* combines in its formula the striking germicidal power of a mixture of cresols and the bacteriostatic activity of an organic mercurial to deal a double blow, antiseptically, against the great variety of organisms commonly encountered in operating room and office practice.

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ANOTHER WAY TO SAVE LIVES....BUY WAR BONDS FOR VICTORY

The Pattern Varies
in Hospitals Under Local Government Control

APPARENTLY one cannot draw a single pattern concerning the method of control of local government hospitals. Methods vary as much as they do in the voluntary hospitals. At least, such is the conclusion that emerges from examination of reports from nine hospitals under control of city, county or state government.

In some instances these institutions are operated almost exactly as though they were voluntary hospitals. In other cases they are an integrated part of local government.

Only nine of the 50 hospitals interrogated sent replies. This probably indicates less interest on the part of the 41 unresponsive hospitals than would usually be true of voluntary hospitals.

Hospital Governed by County

The local government hospital that is completely integrated with other aspects of government can be illustrated by Walworth County Hospital, Elkhorn, Wis., a 75 bed institution under the direction of Margaret Schloemer.

"Our hospital," Miss Schloemer writes, "is governed by a county board committee that is elected for a one year term by the county board of supervisors, which, in turn, is made up of an elected representative from each township, village and city ward in the county."

Asked her opinion as to the best method for selecting the governing body of a city or county general hospital and the authority this body should have, Miss Schloemer states that "the governing body of the city or county should elect a self-perpetuating board of trustees composed of capable men and women of the community to serve not less than three year terms without remuneration. Such a board of trustees should be responsible to the governing body of the city or county but should have all authority for the management of the hospital."

The third question in this inquiry asked what relations the hospital has to the local government and, specifically, whether purchases are made through the local government, whether the local government makes up hospital deficits and whether it controls appointments to the medical and administrative staff.

"All management of the Walworth County Hospital," Miss Schloemer replies, "is vested in the county board committee. Monies received are paid by the hospital to the county treasurer and all bills are paid by him through vouchers issued by the hospital. Reports are given to the county governing board at its regular meetings."

Asked about financing, she states that all money for operating expenses is received from income from patients but funds for new buildings and major equipment are paid from an appropriation granted by the county board from general tax funds after it is determined that such expenditures are necessary.

In this instance there is little voluntary community contribution to the hospital work through gifts, women's auxiliaries or donated goods or services.

"Walworth County Hospital was built for the people of the county by the people," Miss Schloemer continues, "and is, therefore, known as the county hospital. It should not be confused with a purely charitable institution. Because the nearest hospital was located 30 miles distant, it was felt necessary to build one in the county and because all of the towns in the county were small and, therefore, could not undertake such a project individually, the plan described was carried out.

"There are no restrictions on admissions other than the usual ones: no alcoholic, tuberculous or mentally ill patients are admitted."

Much the same arrangement holds for Memorial Hospital of Cheyenne, Wyo., a 133 bed county hospital under the administration of Georgia M. Mann, R.N. The hospital board is appointed by the county commission.

Miss Mann states that she "believes the board should have complete authority in administrative and financial matters, in turn delegating authority to the administrative staff."

Income From Patients and County

The hospital operates on both income from patients and county funds (relative size of the two not being specified) but capital improvements are made from county appropriations. There are few voluntary gifts and no solicitation of funds has been made.

No restrictions on admissions are in force except those common to general hospitals but, she adds, "indigent patients must be turned over to the county physician."

George W. Hilton, superintendent of the 35 bed Mitchell Memorial Hospital of Epping, N. H., states that the three county commissioners are themselves the governing body of the hospital. They are elected for three year terms by the people.

Purchasing is done by the superintendent subject to approval of the county commission. Expenses of the hospital are met by a county appropriation. Capital improvements are put in a county budget, which is submitted to county delegations made up of representatives of all the towns in the county. Little voluntary support is provided. Services are restricted to residents of the towns, the county and old-age assistance cases.

The use of a public advisory board


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MANUFACTURERS OF TEXTILE DYEING AND FINISHING MACHINES AND LAUNDRY EQUIPMENT

is reported by Beaver County Sanatorium of Monaca, Pa., a 60 bed tuberculosis sanatorium under the direction of R. W. Wilson, M.D. The institution is owned by the county and operated by the county commissioners and the superintendent with advice from a board appointed by the county judge. The superintendent does the buying but requisitions and invoices go through the county courthouse. The medical director, adviser and superintendent are all selected by the county commissioners and the advisory board.

As is true of many county tuberculosis hospitals, taxes comprise about 85 per cent of the total receipts, according to Doctor Wilson, with the remainder coming from part-pay patients. Capital expenditures are paid for from these sources of income. Voluntary contributions to the hospital cover only luxuries for patients, such as movies and gifts.

There are no racial, economic or sectarian restrictions on admission of tuberculous patients but only those who have resided for one year in the county and are over 16 years of age are accepted.

A considerably different type of organization is found in the 70 bed Florida Parishes Charity Hospital, Independence, La. Dr. Richard F. Gates, the administrator, reports that this state-owned hospital has no board of trustees. "The hospital is administered by a superintendent, under the direction of the central office of the department of institutions. The department of institutions has one board which functions as a policy-making body for all the institutions operating under the department."

State Department Does Buying

Purchases for this institution are made through the division of property control of the state department of finance. The state makes up the deficits in operating costs. Appointments to the medical and administrative staffs are made by the superintendent through the department of state civil service. Funds for capital expenditures must be included in the budget submitted to the legislature. No voluntary contributions are received by the hospital.

Any emergency case can be admitted to the hospital but patients who can afford private hospital care are transferred as soon as they can be moved. Standards for indigents are set up by the state and these govern eligibility for admission. Only residents of the state of Louisiana can be admitted.

One of the most interesting arrangements was reported by the Chilliwack Hospital of Chilliwack, B. C. This 51 bed hospital is governed by a board of seven members appointed by the two local city councils responsible for the functioning of the hospital.

Two members of the board are councilors, three are representatives of the districts, one member is appointed by the women's auxiliary and one is a representative of the provincial government.

P. E. Russell, who filled out the questionnaire, approves of this method and thinks that complete authority should be exercised by such a board through the chief executive.

The hospital does its own purchasing and the local governments make up deficits when these occur. The hospital board appoints the medical and administrative staffs.

Income is derived from patients (70 per cent), provincial and municipal grants (27 per cent) and donations and miscellaneous sources (3 per cent). Capital expenditures are borne by the local governments with some help from the province.

A women's auxiliary provides all linen supplies and a junior auxiliary cares for nursery supplies. Service is available to all who need it, regardless of residence or ability to pay.

The three remaining hospitals have a different administrative organization. The Community Hospital of Ashland, Ore., (28 beds, K. P. Nims, manager) is owned by the city and leased to the Ashland Hospital Association, Incorporated. The hospital board is elected by this association.

Mrs. Nims believes that overlapping five year appointments by the city council would be the best method of selecting a governing body and that full directive authority should be assigned to such a board.

The city buys some of the permanent equipment for this hospital but the association buys the rest and all of the current supplies; it also appoints the staff members.

The hospital's operating expenses must be paid entirely from its earned income but a new building would come from city revenue. A women's auxiliary assists with mending. The hospital is available to all.

The John Graves Ford Memorial Hospital of Georgetown, Ky., a 26 bed city-county institution, is directed wholly by a self-perpetuating board of trustees, with Sarah White Ford, R.N., as superintendent. Miss Ford suggests that the board should be elected by the people and then given full authority.

The county contributes $5000 and the city $500 each year to the hospital's operating expenses, but in return the hospital accepts all city and county patients recommended by the doctors for a stay of ten days under a permit issued by the county judge. The permit is reissued if necessary. Obstetrical cases, however, are limited to emergencies under this plan.

Some Voluntary Support Given

If no funds for capital expansions are available from earnings, extra money is raised by the various boards. Voluntary support includes an annual tag day, annual pantry shower and benefit bridge party, all sponsored by the senior and junior women's boards. The proceeds are used to buy supplies and new equipment.

The hospital is available to all patients regardless of economic, residential or social conditions, except that Negroes are admitted only for first-aid treatment or for x-ray. Patients with communicable diseases are excluded and those with nervous and mental diseases are admitted for diagnosis only.

The final brief report is from Lucille Davis, superintendent of the 35 bed Park City Hospital, Bridgeport, Conn. The board of this hospital is "appointed by the people," she reports, suggesting that it should be self-perpetuating. The medical staff is elected by the board.

Operating and capital income comes from the state and from gifts. Voluntary support includes gifts, donated goods and services but the extent and character of these were not specified.

The hospital, Miss Davis states, is available to all sick people without restriction.

It is apparent that these hospitals have not developed voluntary sources of support very far, although, doubtless, they could make substantial increases in this direction.

TRUSTEE FORUM

CONDUCTED BY RAYMOND P. SLOAN

Experts Answer the Question—

Hospitals, What Next?

Part I—Financial Support

First of a series of articles prepared for the benefit of hospital trustees by Roman Slobodin, administrative assistant for public relations, Mt. Sinai Hospital, New York

THE last two decades have brought an increasing general interest in the future of the voluntary hospital. This is part of a process of appraisal of the entire field of medical care and public health which has had a notable development during the same period.

Up to the time of the first World War, the community as a whole concerned itself with questions of medical care only to a limited extent. A number of specific fields were marked out for governmental or philanthropic action, for example, the licensing of medical practitioners, sanitation and provision of medical care for the poor. Outside of these sectors, the citizen's health was considered his private affair or a matter between him and his physician.

During the past generation, however, the subject of medical care has been drawn into the arena of public discussion to an ever-increasing degree. It has become a topic of social agitation and political debate and it has furnished the theme for a multitude of books, articles and speeches aimed at a wide audience.

In all of these discussions the position and prospects of the voluntary hospital have naturally been a topic of prime importance. This national and international discussion would seem to be of vital importance to the voluntary hospitals, inasmuch as the attitude of the public and, in the long run, the future of the hospitals are to a large degree being molded in the debate.

Yet in all the mass of literature that has now accumulated on the subject, there is comparatively little that presents the opinion of the voluntary hospitals themselves. An occasional public comment, such as the recent address by Arthur A. Ballantine, vice president of the United Hospital Fund and president of the Greater New York Fund, at the symposium held by the United Hospital Fund in March 1943, some publications by the American Hospital Association, the writings of a scant handful of leaders, such as the late Dr. S. S. Goldwater, constitute the sum of the public presentation of the voluntary hospital's point of view.

It is no exaggeration to say that the majority of the writers and the bulk of the literature on the subject envision more or less drastic changes in the support, control, organization and operation of voluntary hospitals. Most of those who bear the responsibility for these institutions and who uphold the centuries-old tradition of medical philanthropy apparently feel so securely entrenched in public esteem and so independent financially that they see no need to enter into debate to justify the major premises on which their institutions are founded and operated.

It would be beside the point to discuss here whether such aloofness is advisable. But it must be noted that in this summary, representing a cross section of publicly expressed opinions as to the future of the voluntary hospitals, their case on their own behalf is perforce not extensively represented.

Prognoses on the voluntary hospital may be classified into the following major subdivisions: sources of financial support; control of policy and administration; services offered by voluntary hospitals; relations with physicians, and relations with patients (including charges for services).

It is widely asserted that the sources of philanthropic support for hospitals are drying up. Dr. Hugh Cabot of the Mayo Clinic, former dean of the University of Michigan Medical School, says, for example, in "The Patient's Dilemma" (1940) that the rôle of charity in defraying the costs of medical care is diminishing because of the contraction of upper bracket incomes and the "weakening of the concept of charity."

Doctor Cabot foresees that in the future the costs will be paid out of taxes and not by charity. He expresses the hope that this change will be gradual so that "the great structures that have contributed so much to the development of medical care will not be mortally wounded."

Michael M. Davis, chairman of the Committee on Research in Medical Economics, in his book "America Organizes Medicine" (1941) recommends the expansion of federal and state aid for hospital construction. Prof. Barbara M. Armstrong in her work "Insuring the Essentials" (1932), a report on the six year joint survey by the University of California and Social Service Research, maintains that America is clinging to outworn charity concepts in the field of public welfare, including health care.

"Charities which sufficed well enough for the cases of destitution which required assistance in our less sophisticated periods," writes Professor Armstrong, "are expected to cope

with the great sickness, invalidity, unemployment and similar problems produced by the industrialized society of today." It is conceivable that Professor Armstrong might at present be willing to modify or at least postpone this death sentence on charity, indicted during the depths of the depression.

In fact, it is noticeable that many similar judgments by other writers as to the collapse of philanthropic support of hospitals were apparently based on conditions during the worst of the depression years. But there are contributions on the subject, written within the past year or two, that still hold to this view. Doctor Cabot, in fact, says specifically that the depression did not bring about, but only accelerated, the decline in medical philanthropy.

Is Health a Government Problem?

Another line of attack is the widely heard argument that the whole field of health, including hospital care, should be a governmental service like police protection and education. Typical of this reasoning is the statement of Dr. Miles Atkinson in "Behind the Mask of Medicine" (1941): "Charity hospitals are a feudal survival. . . . Charity as the only means of obtaining a necessary commodity like medical attention is out of date, and rightly so."

Similarly, Prof. Henry Sigerist of Johns Hopkins says in "Medicine and Human Welfare" (1941) that "medicine, like education, will ultimately become a public service in every civilized country."

Increasing support of voluntary hospitals by tax funds is also envisioned by many of the physicians whose views were polled by the American Foundation and published in its extensive report, "American Medicine: Expert Testimony Out of Court" (1937).

It is notable that while the hundreds of physicians throughout the country whose views were obtained in this survey expressed a great variety of conflicting opinions on most topics, there is little indication in the report of any outspoken opposition to increased support of voluntary hospitals out of tax funds. Perhaps, however, one may assume that there is opposition to increased use of public monies for this purpose on the part of the many physicians who, the survey reported, believe that adequate medical care is already generally available.

The point of view of a federal health official should be of interest. Harry H. Moore, public health economist of the U. S. Public Health Service, in "American Medicine and the People's Health" (1927) lists among the "next steps" in the development of medical care the establishment of more hospitals and clinics for people of moderate means "with state aid when necessary."

The opinion of Waldemar Kaempffert, science editor of the *New York Times,* is also worth noting. Speaking at the United Hospital Fund symposium in March, Mr. Kaempffert said: "There is no way of dodging taxation if we are to care for the families that must live in normal times on incomes of less than $1000 and even $2000 a year. The American Medical Association admits as much." However, unlike most of those who hold this view, he does not consign medical philanthropy to oblivion.

"Does this imply the abolition of the great voluntary hospitals?" Mr. Kaempffert asks. "The Beveridge Report makes no such recommendation, nor does our National Resources Planning Board. But we must recognize that treatment in a hospital is no longer a privilege granted by charity, but a right."

Doctor Goldwater, in a brief but comprehensive review of the subject published in *Hospitals,* July 1942, goes a step further by pointing out a hitherto comparatively undeveloped potential source of philanthropic contributions. Concurring in the general view that the traditional type of charitable endowment is diminishing and will continue to decline, Doctor Goldwater argues as follows:

"Must voluntary hospitals hereafter look to the government alone for capital funds? Some communities will need help, but the majority of communities should not, for *under present tax conditions corporations, without great sacrifice, can give substantial portions of their gross profits to community hospitals* for necessary plant development; their willingness to do so has been significantly revealed in a number of recent hospital drives." (The italics are ours).

Nevertheless, Doctor Goldwater, too, agrees that hospital expenditures for care of the needy must be met "increasingly, under present and prospective conditions, from taxes." He does not regard this development with apprehension so long as increased support by public funds does not entail government operation or control.

Another point emphasized by Doctor Goldwater, which appears to have been overlooked elsewhere, is the fact that hospital support both under the voluntary system and under a federally supported program comes from the same source—the earnings of industry.

Views expressed in the two recent ambitious social planning studies, the Beveridge Plan in Great Britain and the National Resources Planning Board report in this country, are pertinent. The American plan relies on large-scale taxation to provide the means for "development of adequate public health services and facilities in every county within the country."

Federal appropriations are urged to aid states and localities in developing a system of regional and local hospitals and health centers, distributing physicians, dentists and nurses in accordance with the need. At the same time, the report envisions "continued support from public and private agencies," but without going into details.

Beveridge Plan Not a Panacea

The Beveridge Plan would entail reform and further extension of the compulsory medical insurance system which is now widely in force in Great Britain as it is in most other European countries. It is, of course, a matter of interest to this country that the authors of this study, on the basis of the British experience with compulsory insurance, and despite the admitted shortcomings of the system as it stands, regard it as sufficiently successful to warrant continuation and expansion. On the other hand, the Beveridge Report reveals by implication that a scheme of this kind, merely because it is endowed with the title "compulsory health insurance," is by no means a panacea for all ills.

Summary: There is general agreement that traditional sources of voluntary charitable support for hospitals will continue to contract. It is anticipated that they will be replaced in whole or in part by governmental funds. Whether this will, or should, entail government control is a debated point. A promising new source of voluntary support is corporate giving.

W. W. DAVISON and R. STARR PARKER

Doing Right by Your ROOF

WALTER PROPPER
ROOFING AND SHEET METAL CRAFTS INSTITUTE, NEW YORK CITY

WAR-TIME repairs must be limited to the simplest specifications that will correct a fault, making the building safe and keeping it useful. The War Production Board frowns on the use of materials and labor beyond absolute necessity. Even those materials that are abundant cannot be used freely because materials must be thought of in terms of shipping and labor, both of which are critical factors.

Two Cases of Policy

Two recent incidents in the field of roofing and waterproofing illustrate quite dramatically different aspects of the defense policy. An institution had suffered a fire that had damaged the roof. Without any question the necessary materials were released for restoring the building. This made sense because a structure worth $250,000 was saved by the expenditure of $10,000 worth of material and labor.

In the second instance the flexibility of the principle manifested itself. A well-endowed private school had an excellent peace-time policy of avoiding small repairs. As the roofs of its several buildings deteriorated those responsible did not bother with repairs but, instead, built new roofs. A grand idea, ordinarily, because it saves painting, plastering, water damage and irritation. But this year the problem presented itself again. The normal course would have been to lay a new roof. Instead, however, they repaired the leaks and are waiting for a happier day to lay the new one.

Such repairs are not always simple. The roofs of some buildings have a gravel surface and leaks cannot usually be detected. For such jobs I recommend a blind procedure that has yielded a good percentage of successful results.

If there is a ceiling stain from the leak, the first step is to orient the position with respect to a particular window, marking the sill of the window with a graphite crayon. The window is then identified on the roof and the measurement made downstairs is repeated to locate the exact point over the ceiling stain. The storm water may not enter at this point but enough of the surface is covered to provide against a leak that may be channeled from some distance.

The point located becomes the center of a square, 12 feet by 12 feet. The gravel is scraped off this square and piled to one side for removal as it should not be respread over the roof. Then an asphalt or tar mastic is troweled over the newly cleared surface and a rubberoid roofing material is embedded in it.

Repairs Are Temporary

In making any roof repairs the thought should be kept in mind that they are only temporary and every repair should, in a sense, be a preparation for the new roof that will ultimately be applied.

It may appear that this is going to a lot of work to plug up a leak that is no larger than a nail hole but roofers have learned the wisdom of this treatment for gravel roofs. On a smooth-surfaced roof a square yard of material will usually be just as effective because the breaks and holes in sheet roofing can readily be seen.

To be sure, sometimes too many of them are seen and then it becomes a question of which are the offenders. Very often the superintendent or engineer will lean too heavily on the evidence that meets the eye. I have walked on roofs with superintendents and have seen them point out dozens of small breaks on the top layer of smooth roofing material and give instructions to patch all visible breaks and rifts.

On more than one occasion I have protested, "But those breaks aren't necessarily leaks."

"They could be."

"But they are not," I replied. "The only leaks are those that show up on the ceilings on the top floor. What's the use of patching all the others?"

"Well, at least we can be sure they won't turn into leaks."

This was considered bad roofing practice before the war; today it would be a flagrant waste of resources. The fact is that no matter how minutely you scan the surface of a roof you can't predict where it will leak next.

Beware of Magic Remedies

Many engineers are apprehensive about the buildings under their care. Either their superiors are unduly critical or they feel that when something goes wrong it is a reflection on their ability.

This attitude has plowed a fertile field for salesmen who have panaceas for roof troubles. Not long ago the custodian of a parochial school showed me a sample of a liquid that had been offered to him as a roof repairer and preserver. The salesman had advanced the argument that while there was a shortage of ordinary roofing materials this liquid could be brushed over the roof to fill the cracks and to rejuvenate it. The price was $3 a gallon and only 50 gallons of it were needed to put the roof into first-class shape, according to the salesman.

The argument was fairly persuasive. A black asphalt-like material has an appealing aspect to a man with an acre of roof to worry about.

MORE THAN STARS... Sometimes

when we look at our service flag, we seem to see in its stars the faces of the men who used to work beside us. In such moments we are proud that here at Hoffman we are devoting all our energies to producing war equipment— striving to bring nearer the day of Victory— the day of their return.

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All that was necessary was to send a helper to the roof with the liquid and a long-handled brush and let him go to it. The only reason that the custodian didn't buy the stuff was that he no longer believed in magic. His previous experiences with magic had been disappointing.

Later investigation revealed the liquid to be nothing more than black asphaltum with an inviting name. A similar material could be bought for less than a dollar a gallon.

Black asphaltum certainly cannot harm a roof. How much good it will do has never been determined but, in my opinion, it is not effective enough to justify even its low cost.

I have never heard of any effective roof preservative. My experience with smooth-surfaced roofs has been to leave them alone until they leak, then repair the leaks until they become a nuisance and, finally, install new roofs. In war time you simply let roofs be a nuisance a good while longer.

There are, however, certain ways to extend the life of a roof. A roof that is not intended to bear traffic should not be used as a sun deck or even as a short cut from one department to another. A woman in spike-heeled shoes passing from one end of the roof to the other will do more damage than the year's heaviest cloudburst. We roofers see every day the difference in wear of a roof that is walked on and one that is not.

In peace time it may seem to the owner of the building that, even if he has to rebuild his roof oftener, there is some advantage in allowing it to be used for purposes other than for which it is built. But now, with the need for conserving all that we have, a good roof should be treasured and not abused.

People should be kept off the roof. It should be kept free of rubbish and a periodic examination made of the drains. In heavy rains paper, leaves and silt will wash toward the drains and clog them.

A well-policed roof will pay dividends for the ten minutes a month that are necessary to keep it clean.

Engineers' Question Box

Raising Water Temperature

Question 46: We maintain our domestic hot water supply at only 145°F. What is the most efficient method of furnishing 180°F. rinse water for our dishwashers?—N.S., Mich.

ANSWER: To raise the temperature of the rinse water for the dishwasher from 145°F. to 180°F., install a steam coil booster with regulating valves, which should be connected in the rinse water line with the steam supply from the sterilizer, kitchen or laundry line. —RICHARD T. POWERS, *chief engineer, Charles T. Miller Hospital, St. Paul, Minn.*

Proper Care of Oxygen Equipment

Question 44: Who should be responsible for the physical and mechanical condition of oxygen therapy equipment and why?—O.B., T.H.

ANSWER 1: At Royal Victoria Hospital, Montreal, the responsibility for the upkeep and repair of oxygen therapy equipment of all types is entrusted to the instrument department. This department is staffed by skilled personnel and keeps on hand any of the common parts that are likely to need replacement from time to time.

An oxygen room where all full cylinders are received and issued is also part of the setup. A record is kept of the number of the cylinder, the date of issuance and the person to whom the cylinder was issued. Empty cylinders are returned to the oxygen room, crossed off the record and then picked up by the supplier.

In this room is also located an arrangement through which small cylinders are refilled from large cylinders, a service that is saving in time and money.

By having such an arrangement the maximum use is obtained from every piece of equipment as there are no delays for repairs which, at the present time, may take several weeks. Too, service calls from the dealers with their attendant delays are never required.

Every oxygen tent is inspected and repaired, if necessary, once a week. With the arrangement now in force, failure of any oxygen equipment while in use is at a minimum.—WILLIAM J. JONES, *chief engineer, Royal Victoria Hospital, Montreal, Que.*

ANSWER 2: The anesthesia department should at all times be responsible for oxygen therapy equipment because members of this department are familiar with its operation. Gauges are extremely delicate and if not handled by someone who understands their operation they can be rendered extremely inaccurate.

By virtue of their training, all anesthetists are familiar with oxygen therapy equipment and are well equipped by experience to recognize any inaccuracy or the necessity for repairs.—ED. MANUS, *engineer, Baptist Memorial Hospital, Memphis, Tenn.*

Use Care in Throwing Switch

Question 45. In case of a blackout alarm, can I safely pull the main switch or circuit breaker with the entire load on without damage to the equipment? If not, what is the most expeditious safe way to cut off lights? —R.C., Calif.

ANSWER: I would not advise pulling the main switch or circuit breaker with the entire load on at the time of a blackout alarm. With proper individual circuit breakers on the major pieces of equipment, I am sure that the effect would be no worse than that in a complete and sudden power failure. However, it does not seem advisable to pull the main switch that would cut out stokers, oil burners, ice machines or any other mechanical equipment which must remain in service even though the hospital is completely blacked out.

My suggestion would be to cut out all light switches if they are separate and apart from the main switch or to have sufficient personnel stationed on each of the floors to throw the light switches individually at the time of the

Karl H. York, assistant superintendent of Columbia Hospital, Milwaukee, was the winner last month of the regular monthly $5 prize for the best answer in the Engineers' Question Box. Mr. York took up the problem of the care of oxygen equipment.

Some more questions have come in on which we should like to have you test your skill. Send your answers in and, perhaps, win $5.

47. How can the painted walls of a sterilizing room be prevented from scaling?

48. How can a good system of ventilation be introduced into a nursery where the opening of windows is detrimental and unsafe?

alarm.—KARL H. YORK, *assistant superintendent, Columbia Hospital, Milwaukee.*

ANSWER 2: There is no general rule that would apply in disconnecting power in power plants. The operation depends on the type of installation. In our case we can trip off the overload high-tension circuit breaker without damaging the equipment. That is what happens when the power company trips us off during heavy thunderstorms or other emergencies.

The next most expeditious and safe way to cut off lights is to pull the secondary switches, one after the other.

In any case, the main switch should never be pulled with the heavy load on.

Caution: Before pulling a main switch make sure that there will not be any danger of a flashback. Be certain that the subswitches on the circuit are not loaded.—R. A. ROY, *chief engineer, Royal Victoria Hospital, Montreal Que.*

ANSWER 3: Continuously running motors sometimes fail to start again after the current has been turned off. The result is the burning up of motors. This is especially true in the case of large horsepower motors that are connected to such appliances as ventilating fans and elevator generators. In such cases it is not advisable to pull the main power switch.

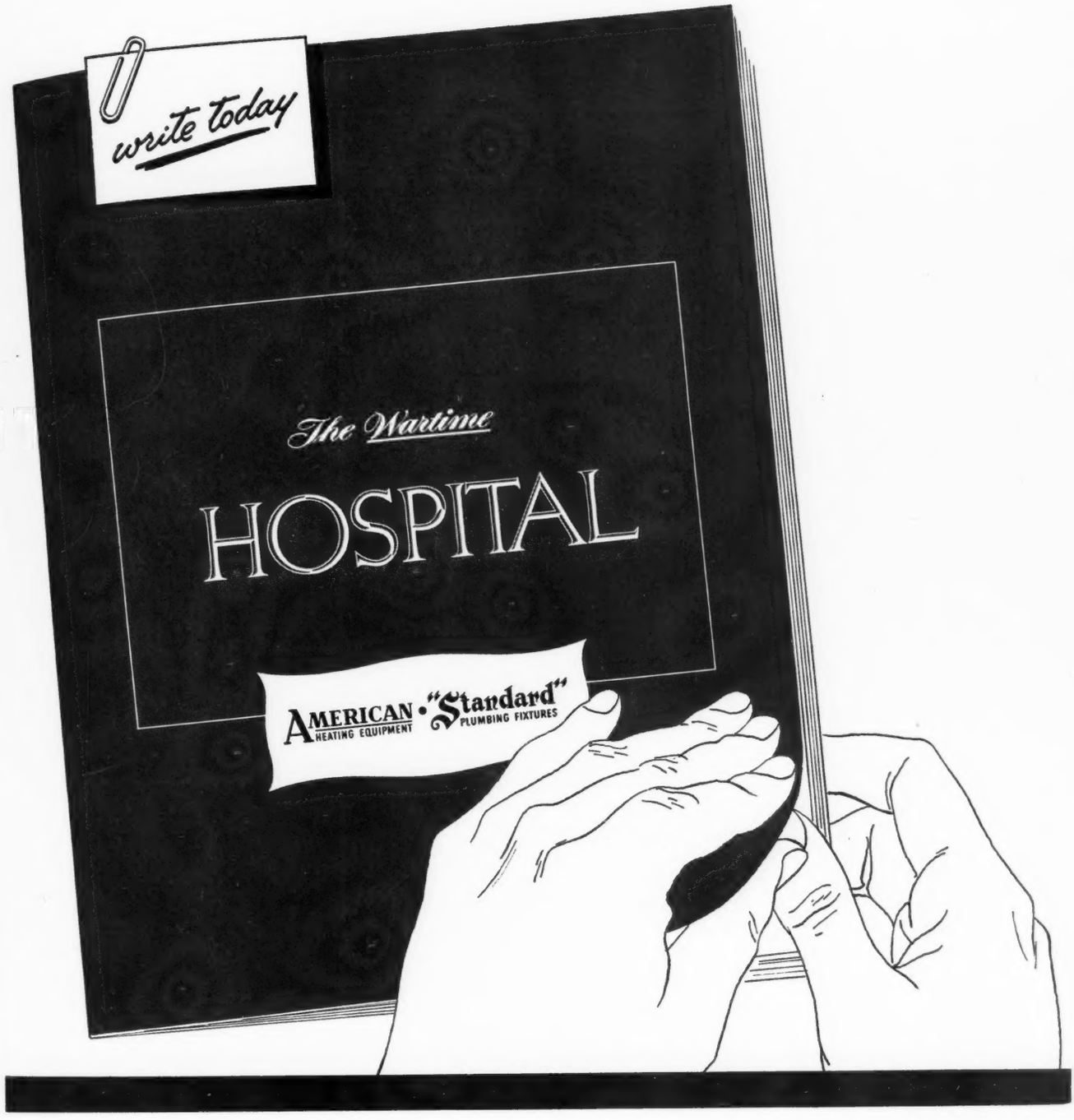
One of the best methods of cutting off hall and room lights, provided these are on separate circuits from the signal system, is to mark the fuse panels controlling these circuits and place them in fuse boxes in various parts of the institution. If these fuses are properly marked, they can be removed or blacked out without affecting the signal system and other appliances wired to the baseboard receptacles.—ED. MANUS, *engineer, Baptist Memorial Hospital, Memphis, Tenn.*

Avoid Spreading Fly Ash

Question 35: If we install a pulverizer, how can we avoid complaints about fly ash?—R.S., Ind.

ANSWER: Pulverized coal equipment is notorious for spreading fly ash through the surrounding atmosphere if it is not efficiently trapped. Boilers designed for use with pulverized coal usually have a fly ash pocket built into the last pass. This often has a vacuum connection so that the pocket can be emptied while boiler is under load.

If possible, enlarge breeching so that the velocity of waste gases is reduced, provide pockets in the base of the breeching to trap fly ash and arrange to remove these fine ashes by vacuum or by dumping into a water-filled pit.—H. F. VOGEL, E.E., *Sunmount, N. Y.*



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HOUSEKEEPING PROCEDURES

Conducted by Alta M. LaBelle

Color Comes Into the Waiting Room

Waiting, for good news or bad, is one of the most difficult tasks imposed on the average impatient human being, especially in a hospital. And if the environment is gloomy, dark and generally hopeless, the spirits of those who wait are likely to sink lower and lower and the feeling of apprehension to grow.

No one who has spent long minutes pacing the floor of a dismal waiting room or squirming on a hard, unsympathetic chair is in the proper frame of mind either to greet a sick friend or relative with the good cheer that is needed to raise his morale or to face the doctor's verdict with equanimity.

There was such a room at Michael Reese Hospital in Chicago—a classic of Mid-Victorian discomfort, with gloomy green walls and heavy dark furniture—to which visitors and out-patients were relegated until it was time to see the doctor or visit their friends.

"And why no one ever broke his neck stumbling up or down those shadowy unlighted steps that led to it" is something that Mrs. Alta M. LaBelle, the housekeeping director, will never know.

That room is gone now, thanks to the generosity of the Chicago Club for Crippled Children, which financed its transformation into a cheerful, thoroughly modern room with plenty of unusual and interesting decorative features that are well calculated to distract the visitor from thoughts of his own woe.

Highlight of the room is a breathtaking photographic mural of the Buckingham Fountain in full play, with the downtown skyline in the background, which occupies the entire north wall. The mural is framed with a surrounding wall of natural oak in the recesses of which are built the indirect lighting fixtures.

The proper amount of light for the photograph was determined only after a great deal of experimenting. On first consideration it seemed advisable to flood the mural with light and a number of 100 watt bulbs were used. This resulted in such an intense glare that it almost obscured the photograph; finally, after many trials, several 7½ watt bulbs were found to give just the right effect—with quite a saving of electricity.

The remaining walls are painted parchment yellow, stippled on, and the effect of permanent sunshine in the room is further enhanced by reflections from a white terrazzo floor.

Telephone booths that formerly occupied the west end of the room were taken out and moved across the hall and a projecting pillar in their vacated space, which could not be concealed, was accentuated in such a way as to make it an unusual decorative feature. An almost triangular box of natural-finish oak was built part way up the wall and in it were planted sansevierias. Concealed lighting in a circular trough back of the plants reflects the yellow wall and makes a bright corner on the darkest days.

Sansevierias are also used to provide a decorative note on the reading tables and at the ends of the radiator grilles.

Those reading tables are unusual, too, both for their L-shape and for the fact that the built-in wooden lamp bases are actually high enough for comfortable reading.

Natural oak finish was used for all of the woodwork, for the soffits that conceal indirect lights in the window areas, for the pilasters that replaced the old mahogany doors, for the finned wood

"THANKS FOR MAKING POSSIBLE SUCH COMFORT!"

—Ketchikan, Alaska

Hospital superintendents and staffs have written us many letters to tell us what the extra comfort of Koyalon Mattresses, Foundations and Pillows has meant to patients... what the ease of handling, what the washability has meant to the staff. Although there are no Koyalon Mattresses available until the war is won, they look forward to the day when Koyalon can be bought again.

"I am sorry to find that we cannot get any more of the Koyalon Foam Mattresses. We first used them in this hospital in May, 1939, and a few months later bought more. All are in fine condition, unsurpassed for cleanliness and comfort. We shall buy more whenever they are available."

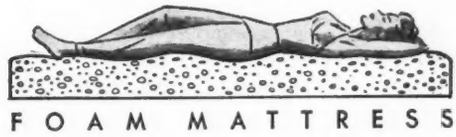
"Koyalon Mattresses certainly have relieved us from complaints of hard beds."

"We have been using your Koyalon Mattresses for over three years and can say they are perfect. Patients all say they are wonderful."

"Our U. S. Koyalon Mattresses have been in use for several years. They give an even pressure which is especially appreciated by our Orthopedic patients who have any back trouble."

"We hope that this emergency will be over soon so we may be able to purchase more of this type of mattress."

Koyalon



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radiator grilles and for the soffit that connects the pilasters across the top of the entranceway. This louvered soffit contains the indirect lighting fixtures and a call system through which out-patients are notified of the time of their appointments.

Incidentally, the wood radiator grilles, which were a war-time measure, have proved to be a surprising improvement over the commonly used metal type. In order to keep the wood from warping and also to protect the plants, the inside of each grille is lined with asbestos.

Comfort and simplicity of maintenance are the keynotes of the furniture. The settees, which are really built-in benches, are upholstered in simulated python leather and the chairs are of antique-green leather. The back and seat cushions of both chairs and benches are of the slip type which are easy to remove when they need cleaning or re-upholstering.

Nursing Office Rejuvenated

Another modernization job has been done at Michael Reese in the nursing school reception room. Formerly, the candidate for the nursing school waited for her interview in what Mrs. LaBelle described with some feeling as "another dismal little green hole," and perhaps wondered if she really wanted to be a nurse after all—in this hospital anyway.

Now, anyone who enters the little room is made to feel at ease by the restful tones of the natural oak woodwork, the soft green leather upholstered chairs and the cheerful English print chintz draperies. The natural beauty of the window is further accentuated by a square-topped arched valence of chintz set inside a valence that matches the arch of the window.

Any maintenance-minded housekeeper would approve of the rug in this room. It is made of linen, bound on all sides, and although it is light in color, cleaning it is no problem. All you have to do is to turn a hose on it, says Mrs. LaBelle. Furthermore, it is one of those rugs that seem to wear forever.

The improvement that modernization has wrought in this room will surely prove a real aid to the nurse recruitment program.

How Does Your Solarium Look?

The word solarium, or sun room, conjures up a picture of a bright warm place in which a convalescent patient can bask in the sunshine and recover his strength in pleasant surroundings. But, suppose there isn't any sun—and that happens often enough, especially in the northern sections of the country.

A well-known paint manufacturer has this to say on the subject:

"Solariums are sun rooms and once were painted almost any color, as the hospital people felt that sunlight was the important thing here. Well, that is fine if the day is sunny, but what if it is raining or snowing or the day is overcast and gray? Where is your sun room then?

"The solarium is used by the hospital as a 'come-on' for the patient who has reached a stage of convalescence. He gets up out of bed and, putting on his robe, walks on shaky legs to the door of his room. He looks down the corridor and there at the end (if the day is bright) is the solarium all golden yellow. He thinks 'I will walk down there and sit awhile, maybe read or smoke.'

"So off he goes, exercising his muscles, getting himself a change of scenery, becoming a part of the busy life of the corridors. But if the day is overcast he looks down the corridor at simply another room as dull and dismal as his own seems to be, and he goes back to bed with a grunt and a sigh.

"So we say—make the solarium seem to be sunny always, no matter what the weather. Paint it all over with sunlit yellow. Then it will always be a spot of cheerful brightness at the end of the corridor beckoning to the patient, giving him the will to exercise and to hasten his recovery."

Food Fights for *Freedom*

- **Increase Food Production**
- **Increase Food Conservation**
- **Increase Food Sharing**
- **Black Out the Black Market**

WITH their usual patriotic point of view, hospital dietitians will not regard as a burden but as their natural privilege the widened rôle they must play during the next few weeks in helping Uncle Sam put over his newest and best organized campaign to the public.

Called "Food Fights for Freedom," it is directed toward the consumer, the food processor and distributor and the farmer-producer.

Set for full swing in November, America's traditional month of Thanksgiving for the harvest, the Food Fights for Freedom drive is already gathering momentum.

W.F.A.'s Four Objectives

On the theory that food is the mightiest weapon of them all, the War Food Administration has planned its campaign around four major objectives. These are:

1. To increase food production—on farms, in orchards, on ranches and in victory gardens.
2. To increase food conservation by avoiding waste.
3. To increase food sharing so that our armed forces and fighting allies are well fed. This requires 25 per cent of our food supply; the remaining 75 per cent must be shared equitably on the home front.
4. To play square with food by killing black markets, discouraging hoarding, observing ration regulations and complying with ceiling prices.

Now as to the application of some of these principles to the hospital. The hospital dietitian can serve this campaign in three distinct ways: (1) by more intelligent and closer planning in her own department; (2) by educating the staff and employes, and (3) by teaching the public through daily contact with patients and visitors.

Most dietitians will exclaim: "I've been eliminating waste and spoilage as many years as I've been on the job. I've reached the limit on that." But if they will read of what their neighbors across the sea, the British dietitians, are doing on much less food they may decide they can plan still more closely.

Dietitians can also serve the campaign by including unrationed foods to the safe limit in every meal. They can be meticulous, as most of them are, in observing ceiling prices and in respecting rationing regulations. Those institutions with victory gardens or farms can take an even larger part in the campaign by canning or storing all possible surplus fresh food.

Education of staff and employes can take place in group meetings at which the hospital administrator assigns the dietitian ten minutes or so to state the case for Uncle Sam. If the hospital has a house organ, the War Food Administration will supply copy and illustrations for use in it.

Display Posters and Slogans

On the walls of dining rooms and cafeterias and in nurses' and employes' residences, Food Fights for Freedom posters should be displayed. If menus are used, some of the insignia and slogans of the campaign should be carried.

Times being so far from normal, the chances are that no hospital dietitian can carry the government's message on food directly to the community through appearance on club programs. Such friendly and worthwhile gestures as public appearances must wait until victory is won. But there are bulletin boards in the hospitals, particularly in the food clinics; there are the necessary personal contacts with those on special diets, and there is the patient's food tray which can carry small messages of explanation, resolve and encouragement to the consumer.

Hospital volunteers, some of whom have some spare time on their jobs during which their morale is likely to sink, might fill in by preparing little paper tents for patients' trays setting forth food facts.

For example, the War Food Administration recently tried out among citizens of New Orleans the two housewife's pledges: not to give away or accept ration coupons and not to pay more than ceiling prices for any product. Some 250,000 housewives signed the pledge. The result: Within two months the cost of living in New Orleans dropped 5½ per cent.

A few facts like that will give the convalescent patient something to think over and to tell his friends who come to visit. They, too, will want to sign the two pledges and keep down living costs.

Crops Decline; Livestock Gains

As to the general outlook for food, there are paradoxes in the situation. There are under cultivation 7,000,000 more acres than last year but a late and rainy spring means that crop production will probably be below that of last year. On the other hand, livestock production has shown a great gain. This means that the total food production will exceed that of 1942. During 1944 there will be still more acreage and also more farm machinery, according to Judge Marvin Jones, federal food administrator.

The dietitian may well make plain to her public that it can't let up on its partnership with the government in respect to food when the war is over, for the destitute of the world must be fed, as must the armies that must be maintained. But, according to Vernon Beatty, consultant to the W.F.A., there will be food enough for all; it is just that there will be certain shortages of "this and that, here and there, now and then."

Every Spoonful Counts!

LENNA F. COOPER

Chief
Department of Nutrition
Montefiore Hospital
New York City

FOOD is as essential for winning the war as are guns and ammunition. Our military forces must be well fed if they are to do our fighting. The caloric food requirements of the average soldier are from 30 to 40 per cent higher than a civilian's and his consumption of meat is about double that of the private citizen. Too, the industrial army of both men and women who are working longer hours and more strenuously than formerly requires larger quantities of food.

Our lend-lease requirements are increasing as is shown by recent official figures. While only 1 per cent of the beef and veal supply was exported for this purpose during the first four months of this year, 15 per cent of lamb and mutton, 13 per cent of pork and also 23 per cent of cheese went to the needy nations overseas. Our armies have already supplied food to the people of Sicily and must be equipped to do so in other countries when their armies capitulate.

It has been estimated that 500,000,000 people throughout the world will need the help of the Allies, much of which will have to come from the United States. It is known that a large percentage of farm animals has been consumed by enemy armies. Even after the war is ended, it will take months, even years, to rehabilitate the populations and to produce the necessary food.

Meat Shortage Increases

In our own country, the shortage of meats is likely to increase because not enough cereals are grown to supply human needs here and abroad and at the same time to feed animals; for when human beings utilize animals as sources of food, approximately 85 per cent of the caloric value of the food fed to the animals is lost.

In times of critical food shortages, it is deemed wise to use cereals chiefly for human consumption rather than for animal feeding. We shall be fortunate if we are able to produce sufficient dairy products (milk, butter and cheese) to supply minimum requirements. In fact, rationing of fluid milk has recently been suggested.

Already some shortages have been experienced, but it is probable that they will increase rather than decrease. Myers, agricultural economist of Cornell University, states in the *Medical Woman's Journal* for August 1943 that "the basic reason for the present food problem is that for more than twenty years prior to the present war, United States food production did not keep pace with population; as a result, our food exports declined, food imports increased and for sixteen years prior to the present war our imports of food exceeded exports." Even though our food production has been above average this year, our needs have greatly increased both at home and abroad, and shipping of imports has been lessened because of submarines and lack of facilities.

The Food Distribution Administration recently stated in the *New York Times* that civilians will be cut approximately 40 per cent on canned fruits and juices and 30 per cent on canned vegetables. They will get about 63 per cent of the meat production, 68 per cent of the fats and oils produced and 80 per cent of the butter. We might just as well be realistic and face the problems that confront us. It is apparent that everyone must be made conscious of the fact that food must be conserved.

The conservation of food involves a nation-wide program including agriculture, processing and distribution, all of which require manpower. To the farmers and their families who have toiled long and laboriously to produce a better than average yield this year, we owe a debt of gratitude. Processors and distributors have also been helped by the women and the youth of the land. But conservation depends chiefly upon the consumer.

When it is remembered that the average person consumes approximately 4½ pounds of food a day, or more than 1600 pounds a year, it is apparent that indiscretion on his part may deprive others of their rightful share of the food supply. A portion of this 4½ pounds does consist of refuse and inedible parts, such as rinds and peelings of fruits and vegetables and bones of meat carcasses.

All too often, however, individuals are wasteful of the edible portion of the food served them and this constitutes "waste" as compared to "garbage" (inedible portion) as defined by the special food committee appointed by the Secretary of the Navy.

A Pound a Day Per Person Wasted

The average housewife who must pay her own grocery bill has sufficient interest in saving to prevent waste both in the kitchen and as food is served at the table. But in institutions where this work is done by paid employes who have little interest in saving, the waste may be excessive. It has been known to be as high as 1 pound or more per person per day.

In one Army hospital during the last World War food waste was reduced to 1 ounce per person per day. Under normal conditions an average of 5 or 6 ounces did not seem excessive. If at all possible, the weighing of food waste is an excellent means of control. If this is not feasible, then careful observation should be made by someone in charge of the service.

In many hospitals the patient's tray is set up complete in every detail and then delivered to the patient. In most cases a generous serving is given in order to provide all that the patient could possibly desire to prevent the necessity of distributing "seconds." This is one cause of waste, for all too often the patient cannot eat the full allotment.

In other hospitals it has been found more economical to serve the tray with the cold foods thereon and to take the food truck into the ward

where the hot foods are served to the patient, who is encouraged to inform the server if any part of the menu is not desired. Only medium-sized servings are given, but the food truck is again brought back for second helpings in case anyone wishes them.

If trucks are not available, the trays may be distributed as described. The hot food is then served in courses by a maid or attendant who carries a tray of bowls filled with soup, for example, to the ward, placing one on each patient's tray if it is desired. While the patients are taking their soup, the dinner plates of meat and vegetables are being served and these, in turn, are taken on a tray to the patients. Coffee and tea are also served at the bedside, either in pots or in cups. This plan not only prevents much waste but also ensures absolutely hot food.

Still another method is to distribute the patient's tray filled with medium-sized servings, which is followed later by a server with a tray or a small hand truck on which are dishes containing "seconds." These are offered to anyone who wants more.

Along with whatever method is used to conserve food, it is also imperative, if best results are to be obtained, to make everyone, patients as well as employes, conscious of the prevailing food problems. This can be done through conferences and demonstrations and by the use of posters and written announcements.

A set of posters similar to the following may be found useful in the employes' and nurses' dining rooms:

1. Be patriotic. Save food. It is needed for our fighting men, our Allies and the liberated peoples.

2. Foods are scarce—meats, milk, butter, eggs, cheese, fats and canned goods. Don't waste them.

3. Join the Clean Plate Club. Accept small portions and return for seconds when you know you want more.

This may seem like one more added responsibility for the already overburdened dietitian but no more patriotic service can be rendered to her country and to humanity than the conservation of food to ensure that every spoonful counts!

How Cooking Affects Vitamins

A CONDENSED summary of the most recent information on vitamin losses in cooking is presented in the accompanying table. Although the data, of necessity, are incomplete, this compilation should make a major contribution to the general knowledge of the subject by indicating the gaps that remain to be filled before a really intelligent and complete picture of the problem can be anticipated.

The Army classification of foods is followed and individual data are presented under subdivisions representing different cooking utensils. No differentiation between poor and good cooking procedures is attempted but the range of values may indicate the extremes of cooking practices encountered.

It is doubtful whether too much significance can be attached to the "average" figures until a larger number of controlled experiments is available. The importance of specifying cooking time, amount of water and type of heat cannot be overemphasized and such data must be available before tables that have a wide scope of usefulness can be prepared.—C. A. ELVEHJEM, *chairman, and* PAUL L. PAVCEK, *secretary, Committee on Food Composition, Food and Nutrition Board, National Research Council, Washington, D. C.*

Vitamin Losses in Cooking Foods

	Vitamin A % Loss			*Thiamine % Loss*			*Riboflavin % Loss*			*Niacin % Loss*			*Ascorbic Acid % Loss*		
	Dis	*Tl*	*T*	*Dis*	*Tl*	*T*	*Dis*	*Tl*	*T*	*Dis*	*Tl*	*T*	*Dis*	*Tl*	*T*
MEATS, FISH, POULTRY (*Beef, lamb, mutton, pork, poultry, glandular organs*)															
Boiling				47*	15*	62*									
Broiling					25	35		10*	20*		10*	20*			
					18-43*	21-50*		0-12	10-23		4-25	18-29*			
Baking						60						55			
						50-70*			57*			49-67*			
Braising					45	45		15	20		15	35			
					27-88	15-51		10-28	19-28*		0-34	26-39*			
Roasting					35	40		10	20		10	20			
					16-55	20-56		0-15	0-61		3-19	2-37			
Frying						25		15	20		25	30			
						0-54		0-33	3-56		0-72	0-64			

(*Continued on Page* 112)

Vitamin Losses in Cooking Foods (Cont.)

	Vitamin A % Loss			*Thiamine % Loss*			*Riboflavin % Loss*			*Niacin % Loss*			*Ascorbic Acid % Loss*		
	Dis	*Tl*	*T*	*Dis*	*Tl*	*T*	*Dis*	*Tl*	*T*	*Dis*	*Tl*	*T*	*Dis*	*Tl*	*T*
Stewing					43&65*	40-82		10*	35*		10*	50*			
Steaming											10 0-15*	40* 34-46			
All methods				47*	35 6-88	40 0-82		10 0-33	20 0-61		15 0-72	30 0-67			
EGGS															
Boiled and scrambled						20*			20-25*			25*			
CEREALS, GRAIN PRODUCTS															
Bread						10-15			0			10			
Grain products						0-10			0			Negligible			
BEANS, OTHER LEGUMES, NUTS (DRY)															
Baked, boiled, pressure cooked						0-32**			0			16 8-25**			
VEGETABLES—LEAFY GREEN OR YELLOW															
Leafy Green (Beet Greens, Brussels Sprouts, Cabbage, Chard, Spinach, Turnip Greens)															
Boiled			30* 6-61	20** 8-32	25** 17-40	35** 25-53			20* 6-38	5* 0-11	20* 12-26	25* 17-37	25 12-66	15 0-56	45 15-78
Steamed									20* 14-27			15* 4-19	20 5-50	15 6-26	30 6-76
Pressure													15* 8&18	5* 2&5	30* 13-53
Sautéed															55** 49&59
All methods			30* 6-61	20 8-32	25 17-40	35 20-53			20 6-38	5* 0-11	20* 12-26	20 4-37	25 5-66	15 0-56	45 6-78
Green and Yellow (Asparagus, Green Beans, Broccoli, Kohlrabi, Okra, Peas, Peppers, Squash, Sweet Potatoes)															
Boiled			25 0-79	10 0-31	15 0-59	25 0-64			5** 0-13	5 0-13	10 2-35	20 5-42	25 12-48	10 2-45	40 6-69
Steamed												0*	10 0&18*	15 14&14*	25 14&32
Sautéed															50 0-76
Baked			10 8-11**												40 6-72**
Pressure															40** 12-58
Waterless cooker															50** 48-50
All methods			20 0-79	10 0-31	15 0-59	25 0-75			5** 0-13	5 0-13	10 2-35	15 0-42	25 0-48	10 2-45	40 0-76
POTATOES															
Boiled			7*	13*	20*	25 10-36			25* 9&43	10* 2-19	5* 4-12	20 8-31	5*	19*	25 0-46
Baked						40 16-35									35 0-73
Fried															35 27-51
All methods			7*	13*	20*	30 10-55	7*	5*	20* 9-43	10* 2-19	5* 4-12	20 8-31	5*	19*	30 0-73

(*Continued on Page* 114)

TOASTMASTER TOAST makes meatless dishes more nutritious...more delicious!

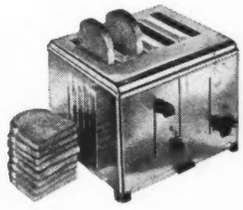
How can you keep your menu ALIVE these meat-scarce, point-rationed days? It's a tough job—but Toastmaster Toast can make it much easier! Use it in the recipe with left-overs, with meatless dishes to make each serving more delicious . . . to fill the plate with satisfying goodness . . . to add tempting variety to war-restricted menus! That's what smart dietitians are doing these days (that is, those lucky enough to have a Toastmaster Toaster!). Try it and you'll be amazed *how much* you can add with crisp, "just-like-home" Toastmaster Toast that costs hardly anything!

HERE'S AN IDEA! Make a cream sauce of flour, milk with butter, margarine or oil. Add minced onion, mushrooms, cooked shrimps and an egg. Season with salt, pepper and tabasco sauce. Cook until thick and smooth, serve piping hot on Toastmaster Toast. Garnish and add extra toast triangles. Looks tempting—tastes delicious! For other suggestions send for our FREE RECIPE BOOK.

"Toastmaster" is a registered trademark of
McGRAW ELECTRIC COMPANY, Toastmaster Products Division, Elgin, Illinois

TAKE GOOD CARE OF YOUR TOASTMASTER TOASTER

Your Toastmaster Toaster was built for years of finest service. If you clean it daily, don't let careless help abuse it, it will serve you well until our factory can again fill civilian needs. If it needs adjustment or repair, see your dealer at once or write us. If you need new parts, be sure to return the old ones.



STRETCH HARD-TO-GET FOODS WITH DELICIOUS

TOASTMASTER REG. U.S. PAT. OFF. *Toast*

THE NATIONAL HABIT
WHEREVER FOLKS EAT!

Vitamin Losses in Cooking Foods (Cont.)

	Vitamin A % Loss			Thiamine % Loss			Riboflavin % Loss			Niacin % Loss			Ascorbic Acid % Loss		
	Dis	*Tl*	*T*	*Dis*	*Tl*	*T*	*Dis*	*Tl*	*T*	*Dis*	*Tl*	*T*	*Dis*	*Tl*	*T*
VEGETABLES OTHER THAN LEAFY GREEN OR YELLOW (*Beets, Cauliflower, Celery, Corn, Cucumber, Eggplant, Lima Beans, Onions, Parsnips, Rhubarb, Rutabagas, Sauerkraut, Turnips*)															
Boiled			5 0&5**	10 4-12**	40 6-80**	45 9-92			20 10-53	15 0-31	15 2-26	35 8-54	25 0-41	10 0-17	35 0-77
Steamed				50*	5*	55*			10 5-17			30** 6-61	10** 0-19	10 4-14	30 14-69
Pressure													5 0-11	15 0-36	35 8-70
Waterless cooker															55 49&66*
Sautéed															50 22-60
Baked															20 12-27**
All methods			5 0&5**	20 4-51**	30 4-80**	45 9-92			20 5-53	15 0-31**	15 2-26**	30 6-61	25 0-41	10 0-36	35 0-77
FRUITS, OTHER THAN CITRUS															
Apples, all methods of preparation															80
Other fruits (*i. e.* plums, bananas, apricots)															30-40
Berries															15*
DRIED FRUITS	Negligible*														0-5*

Legend:
Dis—dissolved Tl—thermal loss T —total loss *—one laboratory **—inadequate data

Three companion soup items widely endorsed for outstanding flavor, time and money-saving advantages.

Greater economies for
HOSPITALS • HOTELS
SCHOOLS • CAFETERIAS
CAMPS

Chicken Soup for instance . . .

quickly and easily prepared from SUNFILLED concentrated Chicken Soup Base, brings to your patients or patrons the savory, full-flavored qualities of a real old fashioned soup. Richness, enhanced by golden globules of chicken fat . . . parsley and other taste-stimulating ingredients essential to the well balanced recipe.

Expressly packed for hospital and institutional use, Sunfilled concentrated and dehydrated Soup Bases can play an important role in your wartime economy. The time required to prepare any desired quantity is cut from hours to minutes. Demands on labor are reduced to a minimum. Fuel consumption is negligible. Aside from their practical value in conserving rationed meats, expensive fowl and vegetables, they serve as a welcome vehicle for left-over foods such as rice, noodles, etc., which might otherwise be wasted. Excellent to enrich gravies, dressings, mashed potatoes, etc.

Keeping qualities permit us to guarantee the freshness of these superior products for a full year. No refrigeration is required. Cost per 6 oz. serving? . . . only 1⅛-2¼¢ depending upon the size commercial containers ordered.

ORDER TODAY or request our representative to call for demonstration.

CITRUS CONCENTRATES, INC.
Dunedin, Florida

What's a famous hotel's inspiration got to do with HOSPITALS?

LET'S START from the beginning: The Waldorf-Astoria, for all its fame and swank, was just as upset as all of us by rationing and food shortages.

Lunches especially were getting to be a serious problem.

INTO A HUDDLE

So Mr. Boomer and his department heads went into a huddle and this is what they saw:

One plentiful food which was not rationed (and not likely to be) was ready-to-eat cereals with whole-grain nourishment.

Coupled with the fact that light, nourishing lunches seemed to be gaining popularity, "cereals for lunch" looked like a "natural." And it has been going great guns from the start.

That's how the Waldorf-Astoria Lunch Idea was born!

CEREALS+GLAMOUR=SMASH HIT!

Of course, the basic "cereals for lunch" idea was glorified to the Nth degree in typical Waldorf-Astoria style.

Such favorites as Post Toasties, Grape-Nuts Flakes, Grape-Nuts, and Post's 40% Bran Flakes blossomed out on the Waldorf menu . . . dressed up like movie stars for an opening night.

Appetizing fruit combinations, and unusual garnishes made these dishes seem altogether new and wonderful.

LIGHT LUNCH—BIG PUNCH!

Around these nourishing, unrationed cereals Waldorf guests can build themselves a complete lunch . . . a light lunch with a BIG PUNCH!

And are they doing it? Just ask the Waldorf!

A GOOD HUNCH FOR HOSPITALS

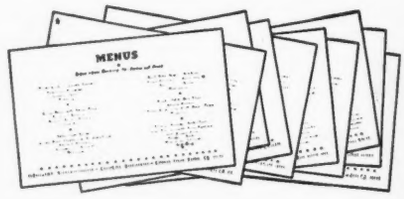
Right now . . . today . . . you can lick one rationing problem to a standstill.

Take a leaf out of the Waldorf's menu book and start serving *Cereals, Lunchtime Style*, in your hospital.

STUDY THEM—SERVE THEM!

To help you get started immediately, study the appetizing, nutritious luncheons on the opposite page. The Waldorf's patrons are going for them . . . and so will your patients.

HERE'S REAL HELP—FREE!



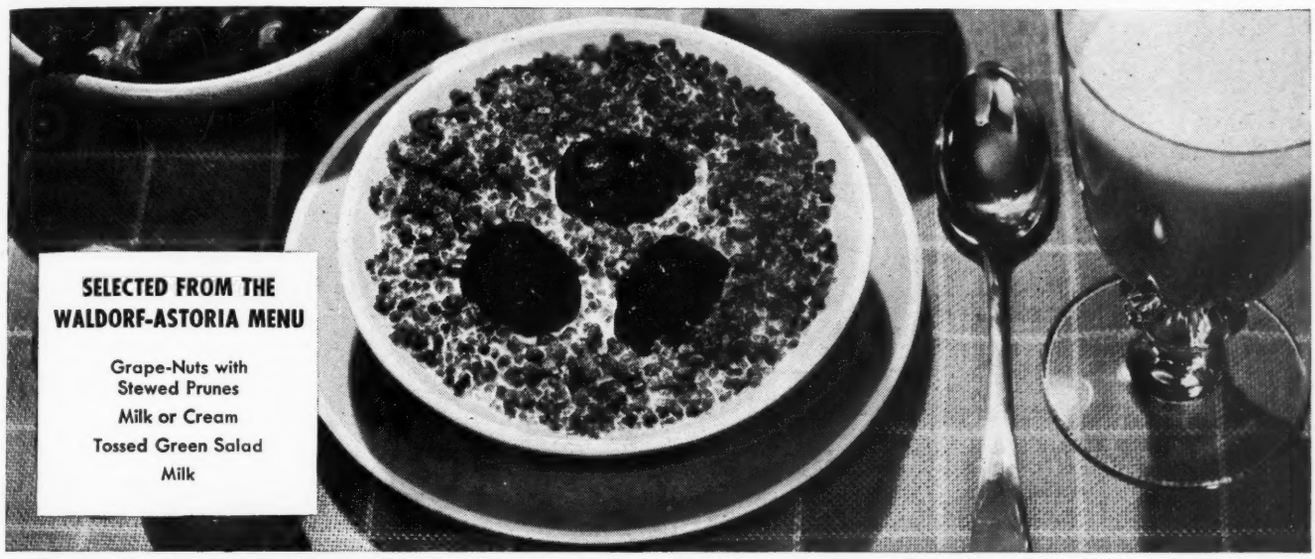
Send today for our set of new and appetizing luncheon and supper menus, starring ready-to-eat cereals. Featuring nutritive value as well as appetite appeal.

Also attractive menu tip-ons and back-bar strips in color. Write to General Foods, Box 31, Battle Creek, Michigan.

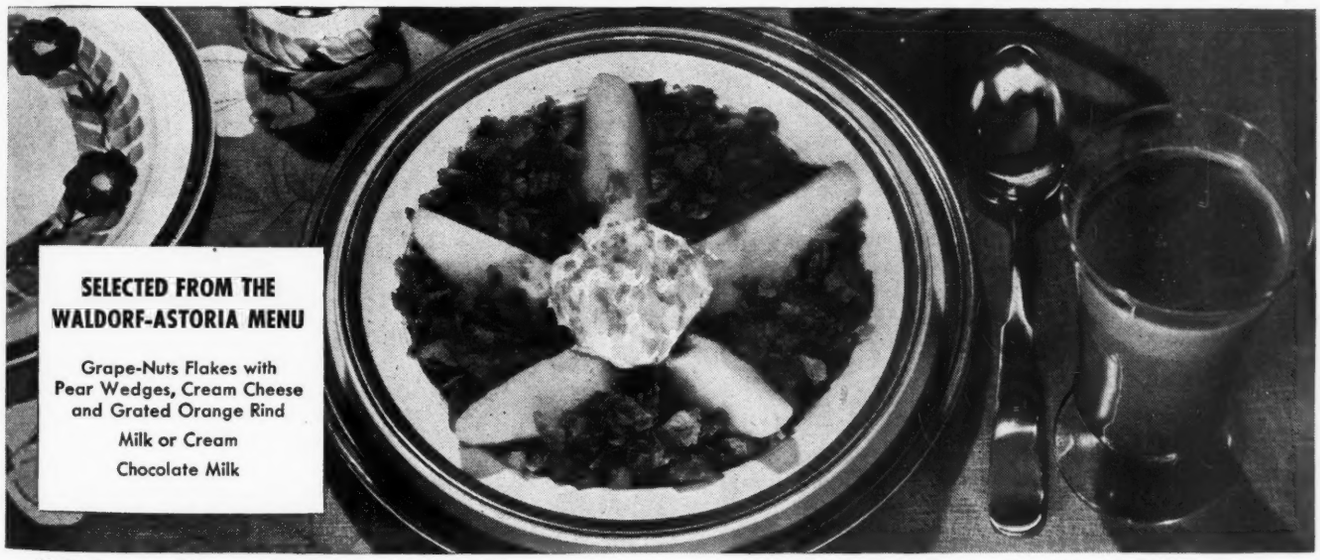
Please your patients, ease your shortages . . . with

The Waldorf Idea —cereals lunchtime style

Chef's pet—guest's pet! It's Toasties Waldorf! You start with a generous helping of crisp, honey-colored Post Toasties . . . crown it with a fruit-filled mold of shimmering Jell-O . . . add plenty of fresh milk or cream . . . and presto! You have a real, grade-A lunchtime hit! Grand for supper, too. Try it.



A prize lunch—a wise lunch! For the diner who has a full afternoon's work ahead, this tempting lunch is insurance against that usual 4 o'clock let-down. The combination of sweet-as-a-nut Grape-Nuts, big, juicy, stewed prunes, and plenty of milk or cream, is a satisfying as well as nourishing meal. Feature it for patients as well as your staff.



Light lunch—big punch! Tender, juicy pear wedges, with orange rind to add a little tang, garnished with rich cream cheese, attractively arranged in a bowl full of golden brown, malty-rich Grape-Nuts Flakes. There's a dish for you . . . light, yet full of nourishment! It's a recipe for sheer delight. The fussiest person will love it!

November Dinner Menus for the Small Hospital

Maude A. Perry

Consulting Dietitian, San Diego, Calif.

Day	Soup or Appetizer	Meat, Fish or Substitute	Potatoes	Vegetable	Salad or Relish	Dessert
1.	Vegetable Soup	Roast Beef	Browned Potatoes	Buttered Spinach	Asparagus Salad	Pineapple Upside-Down Cake
2.	Tomato Soup	Rice Croquettes, Cheese Sauce		Buttered Beets	Waldorf Salad	Floating Island
3.	Cream of Celery Soup	Lamb Chops	Escalloped Potatoes	Buttered Peas	Tomato Salad	Lemon Soufflé
4.	Scotch Broth	Baked Ham, Raisin Sauce	Sweet Potatoes	String Beans	Perfection Salad	Vanilla Ice Cream
5.	Cream of Tomato Soup	Baked Fish Fillet, Lemon	Stuffed Potatoes	Harvard Beets	Romaine Salad	Apple Pie
6.	Split Pea Soup	Beef Stew	Boiled Potatoes	Buttered Asparagus	Tomato Aspic	Lemon Pudding
7.	Consommé	Roast Chicken	Mashed Potatoes	Creamed Cauliflower	Celery Hearts, Olives	Maple Frangs
8.	Cream of Corn Soup	Roast Lamb	Mashed Potatoes	Buttered Carrots	Pineapple and Cottage Cheese Salad	Apple Betty
9.	Fruit Cocktail	Stuffed Tomatoes	Parsley Potatoes	Creamed Asparagus	Head Lettuce Salad	Pumpkin Pie
10.	Vermicelli Soup	Meat Loaf	Lyonnaise Potatoes	Creamed Onions	Coconut, Celery, Apple Salad	Bavarian Cream
11.	Mulligatawny Soup	Chicken Pie	Mashed Potatoes	Buttered Peas	Carrot and Raisin Salad	Fruit Gelatin
12.	Fruit Cup	Fried Halibut, Tartare Sauce	Escalloped Potatoes	Buttered Frosted Spinach	Tomato Salad	Bread Pudding
13.	Vegetable Soup	Swiss Steak	Parsley Buttered Potatoes	Escalloped Corn	Fruit Salad	Tapioca Cream
14.	Fruit Cocktail	Chicken Fricassee	Mashed Potatoes	Baked Hubbard Squash	Lettuce, Thousand Island Dressing	Hot Gingerbread, Whipped Cream

(Continued on page 120)

Jimmie got a germ* and hit a homer!

*the protective wheat germ in hot Ralston cereal

FREE TO HOSPITALS

New tested recipes using cereals as ration-stretchers. In quantities to serve 6 or 50. On handy 4 x 6″ cards. Use coupon below.

2 KINDS OF HOT RALSTON CEREAL

Both are whole grain wheat with ADDED natural wheat germ

One reason so many hospitals
Serve hot Ralston to patients and staff
And use it as a meat-extender
Is that this hot whole wheat cereal
Has extra amounts of natural wheat germ
To make it extra-rich in B-vitamins
Extra-rich in proteins, too.
This wheat germ also gives hot Ralston
A delicious heart-of-wheat flavor
Enjoyed by young and old.
Serve hot Ralston often—it's unrationed
And a serving costs less than a cent!

USE THIS COUPON

Ralston Research Laboratories,
31 Checkerboard Square, St. Louis 2, Mo.

Please send, without cost or obligation, a set of your new quantity recipes for hospital use.

*Name*_____ *Title*_____

*Hospital*_____

*Address*_____

November Dinner Menus for the Small Hospital

Day	Soup or Appetizer	Meat, Fish or Substitute	Potatoes	Vegetable	Salad or Relish	Dessert
15.	Lentil Soup	Liver and Bacon	Creamed Potatoes	Buttered Parsnips	Ginger Ale Salad	Caramel Sponge
16.	Celery Soup	Cheese Soufflé	Mashed Potatoes	Buttered String Beans	Grapefruit Salad	Chocolate Pudding
17.	Cream of Spinach Soup	Roast Lamb	Mashed Potatoes	Carrots and Peas	Romaine Salad	Coconut Cream Pie
18.	Tomato Bisque	Broiled Steaks	Lyonnaise Potatoes	Italian Squash	Waldorf Salad	Rice Gelatin
19.	Cream of Corn Soup	Salmon Loaf With Creamed Peas	Mashed Potatoes		Apple and Celery Salad	Banana Cream Pie
20.	Bouillon	Baked Ham	Mashed Potatoes	Buttered Spinach	Beet and Celery Salad	Vanilla Ice Cream
21.	Tomato Juice	Baked Chicken	Riced Potatoes	Corn Fritters	Tomato Jelly Salad	Apple Pie
22.	Vegetable Soup	Lamb Fricassee	Rice	Hubbard Squash	Banana Salad	Spanish Cream
23.	Cream of Tomato Soup	Eggs à la Goldenrod	Baked Potatoes	Creamed Celery	Fruit Salad	Indian Pudding
24.	Creole Soup	Chicken Croquettes	Mashed Potatoes	String Beans	Carrot and Raisin Salad	Coconut Custard Pie
25.	Consommé	Roast Turkey, Dressing	Mashed Potatoes	Cauliflower, Hollandaise Sauce	Celery, Olives, Cranberry Sauce	Pumpkin Pie
26.	Cream of Spinach Soup	Baked Fish With Dressing	Potatoes au Gratin	Buttered Peas	Lettuce, French Dressing	Fruit Gelatin
27.	Cream of Tomato Soup	Stuffed Beef Heart	Glazed Sweet Potatoes	Buttered Turnips	Coleslaw	Macedoine of Fruit
28.	Bouillon	Chicken Pie	Mashed Potatoes	Broccoli	Combination Salad	Orange Sherbet
29.	Cream of Lima Bean Soup	Roast Lamb	Mashed Potatoes	Creamed Onions	Pear and Cottage Cheese Salad	Butterscotch Pie
30.	Tomato Juice	Peanut and Carrot Loaf	Creamed Potatoes	Boiled Cabbage	Fruit Salad	Strawberry Ice Cream

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This advertisement was published by Libbey in TIME, Sept. 13, and The NEW YORKER, Sept. 18.

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"Don't Put Off Till Tomorrow—"

That Program of Tuberculosis Control

W. H. OATWAY JR., M.D.
Tucson, Ariz.

THE management of tuberculosis in general hospitals now has such a definite outline that it should be on every list of possible procedures —even on the "must" list.

It may be subdivided into several approaches. Some are more feasible than others in war time, but the war will probably speed their general adoption. They should eventually include:

1. Diagnosis of all tuberculosis among the general admissions to a hospital.
2. A simple, planned segregation of new and previously known cases, using simple but precise infectious disease precautions.
3. A case-finding and observation program for all personnel groups, especially those in contact with patients.

They Are Necessary and Possible

Two basic questions about these approaches arise logically and at once: "Are they necessary?" and "Are they possible?" These questions have been arising ever since hospitals and tuberculosis were first discussed together as far back as 1908. The answers have always been "yes," but they can be said with more assurance at present.

Wisconsin General Hospital, Madison, has evolved a control program over a period of eight years. Part of the efforts have been groping and discontinuous, but most of them were regularly planned. During these years a mass of results has been piled up. This evidence shouts in favor of the general principles that have been stated.

The results prove nothing that has not been known but give emphasis to scattered facts and demonstrate that a complete program of tuberculosis control is possible.

The hospital has an average daily census of 640 patients. It has the usual diverse services of a teaching hospital. Known cases of tuberculosis are admitted to the hospital whenever necessary and are isolated, usually on the tuberculosis service. This separate service has included 45 beds for the last two years, 25 for the previous four years and 10 for the three years preceding.

Physical examinations are well done during the teaching routine in the hospital. Every effort is made to recognize unknown cases of tuberculosis and to isolate them. About 50 per cent of the patients have chest x-ray tests as a part of their examination and cases of pulmonary tuberculosis are thus found.

Surveys at various times have shown that this amounts to a considerable number of patients. In 1939, the discharge records showed that 1.8 per cent of 14,000 admissions had tuberculosis. In 1940, 1.21 per cent of the patients on the general wards were seen in consultation by the chest service and the diagnosis of tuberculosis was confirmed. Twenty-six per cent were infectious when seen, as were 40 per cent the previous year.

In 1936 it was demonstrated that nothing less than routine x-ray examinations would be sufficient. All patients who had not had a chest film for a specific reason (50 per cent), during a period of three months, were examined routinely by means of a film. Definite pulmonary tuberculosis was found in 2/3 per cent of this group; 1 per cent was considered active. Twenty-one per cent had some other evidence of tuberculous infection.

Although these findings were definite, it has not yet been feasible to adopt the method permanently.

The hospital personnel is composed of about 275 medical students, 70 interns and residents, 65 senior visiting staff members, 120 student nurses, 240 graduate nurses and 450 nonnursing employes—a total of about 1200 individuals.

All Employes Examined

These groups are now thoroughly and regularly examined at the time of employment and at regular intervals thereafter. The methods vary with the age and the amount of contact with patients. The development of this program has been skip-stop in practice, while heading toward the goal, but constant in theory.

In 1935 an abortive attempt was made to make x-ray examinations of all graduate nurses and nonnursing employes. The program lacked a supervisor and only 75 per cent were examined. Two nurses were found to be infectious and were sent to a sanatorium. The survey was not immediately continued.

In 1936 a recurrent x-ray examination of all nurses known to have lesions was begun. This involved from 12 to 20 nurses. They were checked for changes in clinical and x-ray condition every two to six months. Only two nurses were forced to leave during a five year period for unhealing lesions, and they had been employed with that reservation.

Since 1936 all employes of the tuberculosis service have been given x-ray examinations at from four to

NOTE: The tuberculosis control program described here was developed in association with the late Dr. Reuben H. Stiehm.

five month intervals. Only nurses with positive tuberculin tests are employed. Several with arrested lesions have been allowed to work there. A strict routine of infectious disease precautions has been in use. No nurse developed a lesion on the service; one developed an acute lesion after leaving the service during an epidemic of bronchitis.

The incidence of new infection among the student nurses was found to total 10 per cent for three years (as compared with 6 per cent for college girls). Those nurses who spent short periods (two weeks) on the tuberculosis service had no greater tuberculin test increase than those on the general services. During two periods of six months no nurse was found positive after the service.

Thirteen of the interns and residents who served on the tuberculosis service began with a negative tuberculin reaction. Eighty-five per cent were still negative at the next six months' test. Three served between three and six months with a persistent negative reaction.

How the Survey Was Made

The recurrent survey methods that are used at present for personnel groups were started between 1934 and 1940.

1. *Medical students* are examined yearly by tuberculin tests and/or x-ray films. They have usually had such a routine in college. Their first contact with patients is in the sophomore year.

It was found that the incidence of new infection was variable. From 25 to 30 per cent were positive at the start of the four years. From 40 to 60 per cent were positive at graduation.

About one student per class developed a lung lesion during the four year course. This may have been due to their college survey program, to a limited clinical contact, a low percentage of infection and a short interval after the new infections. The new lesions tended to occur in newly infected students.

2. *Student nurses* have been examined every six months since 1934 by the tuberculin-x-ray routine. Their contact with patients begins in the third year of a five year course.

The incidence of infection among students is also variable. From 12 to 40 per cent have been positive at the start of their course; from 30 to 55 per cent have been positive after five years.

The occurrence of lung lesions was occasional (2.3 per cent or 0.77 per cent per year). The most interesting fact was that again all new lesions occurred in newly infected students.

Special tuberculin testing of the negative reactors two months after their work on the tuberculosis service has shown a lack of special hazard.

3. *Interns and residents* have been examined by tuberculin and x-ray film since 1937.

About 75 per cent of the interns and 90 per cent of the residents are infected at the time they begin service. The difference is due to longer contact with patients by the latter group.

A variable percentage becomes infected each year, and this has tended to decrease in recent years, perhaps owing to the precautions taken.

Residents invariably have a higher incidence of disease on employment than do the interns. The ratio averages 5 to 1. The relative incidence of new disease has the same tendency, with a more than 2 to 1 ratio.

A startling fact is that the relative occurrence of new disease has been 6.5 times as frequent in the women medical officers as in the men.

4. *Visiting staff* members were least cooperative in completing the simple x-ray examinations. Whereas 100 per cent of the other groups responded, 18 per cent of the staff failed to have x-ray examinations after repeated urging. This is similar to the experience in other hospitals.

Tuberculous lesions were found in 5.4 per cent of those examined. All were minimal and inactive.

5. *Graduate nurses* (193) and *nonnursing employes* (434) have again been included in a regular survey since 1940. Both tuberculin and x-ray tests are used at the time of employment, and x-ray examinations are given yearly thereafter. Full-sized films are routinely used, but in 1941 they were duplicated by photofluoroscopic 4 by 5 inch films.

Nontuberculous abnormalities were regularly found. Most were cardiovascular and bronchial; the nonnursing group, being older, had the higher incidence; several were of definite importance (a neuroma, a mediastinal mass, hilar nodes, gross heart changes).

Evidences of tuberculous infection (excluding disease) occurred in about 18 per cent of each group. The nurses, though younger, had had heavier exposure.

Tuberculosis disease was found for the first time in 3.6 per cent of the nurses and 3.7 per cent of the other group. Including previously known lesions, 8.8 per cent of the nurses and 4.3 per cent of the other group were found to have the disease. The figure for the graduate nurses is extremely high.

Tuberculosis in the older nonnursing employes was farther advanced. Four had gastric aspirations positive for tubercle bacilli.

In the first yearly resurvey, 635 were examined by x-ray. None of 491 employes on the general services showed any change; 58 new employes had no disease in the chest; 46 on "contact services" showed no change. Of the 38 people known to have tuberculosis, 10.5 per cent showed an increase in disease. This figure is higher than in other years. (All of those with activity had been in sanatoriums; they had a total of 17 work years since that time).

6. In addition to survey methods, a vigorous cooperative scheme of *segregation and infectious precautions* has been in use. This is essential to any control program.

7. *Vaccination* of the preclinical student nurses and medical students with BCG has been done on a voluntary basis since September 1942. The multiple puncture method of Dr. Sol Roy Rosenthal and his vaccine and instruction have been used. (Dr. Helen Dickie has succeeded Dr. Reuben H. Stiehm in the student health service.)

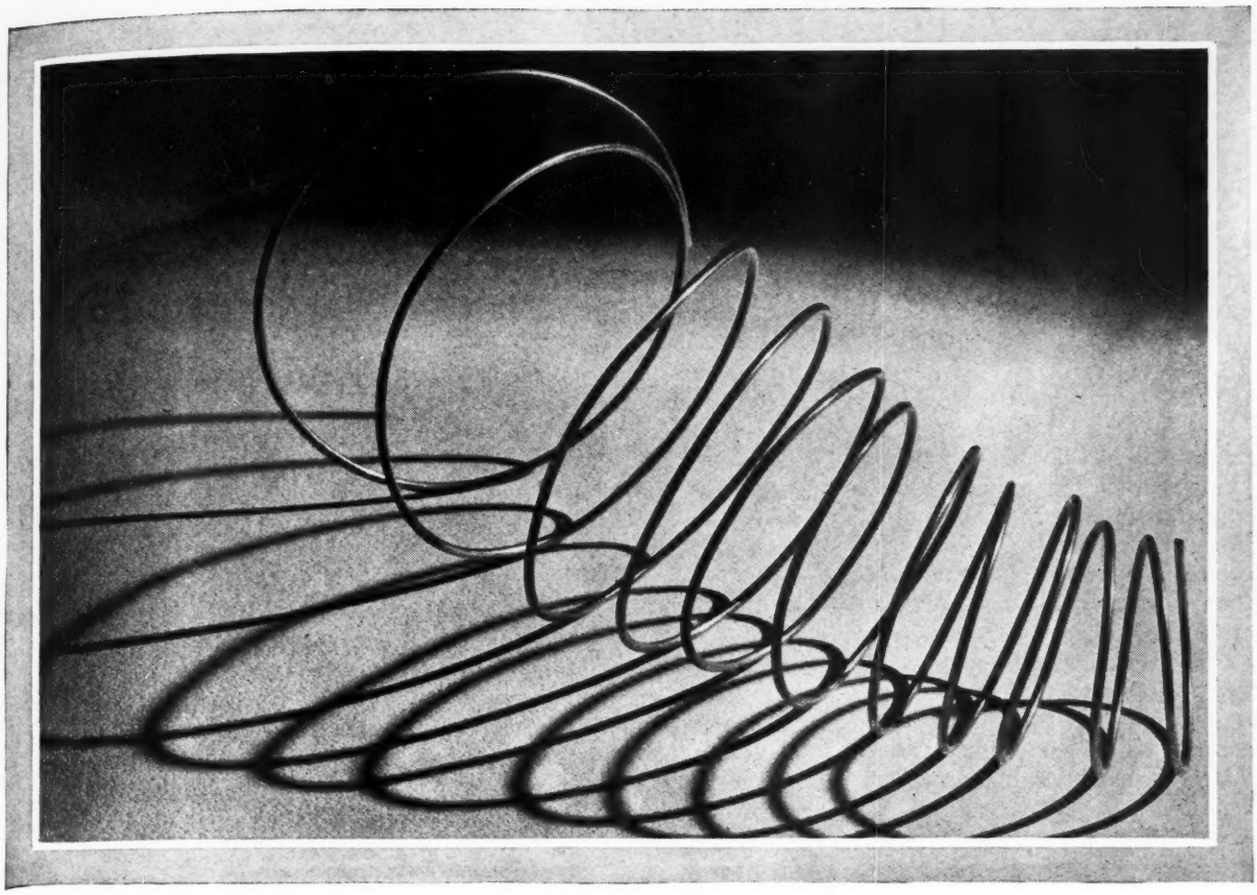
Vaccination Is Beneficial

The staff believes that vaccination has a salutary protective effect and that it is harmless and rarely complicated.

It is possible to install a tuberculosis finding program in a hospital of any size.

The functioning of the routine can be simple if there is cooperation among a clinician, the x-ray department, the hospital management, the nursing supervisor and, perhaps, a student health service.

Prevention, discovery and treatment of all tuberculosis within the hospital walls can lead to its local control.



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SYNTROPAN 'ROCHE'

O.C.D. Advises on New Technics for Treating Burns and Wounds

NEW technics in the treatment of burns are incorporated in the pamphlet, "Treatment of Burns and Prevention of Wound Infections," recently issued by the medical division of the Office of Civilian Defense.

The recommendations contained in this pamphlet are based on recent directions of the committee on chemotherapeutic and other agents and the subcommittee on burns of the committee on surgery of the division of Medical Sciences, National Research Council.

Originally drawn up by these committees for the armed forces, the recommendations have been modified to adapt them to the problems involved in the treatment of civilian casualties.

How to Care for Burns

The emergency care of burns is outlined as follows:

"Whenever casualties with extensive burns can be admitted to hospitals without delay and definitive treatment can be instituted promptly, morphine sulphate, one half grain, should be administered at the scene of the incident and no local therapy should be applied to the burned area except sterile gauze to exposed surfaces to prevent infection."

The most notable change in the O.C.D. pamphlet is the withdrawal of the recommendation of the use of ointments or jellies containing tannic acid in the first-aid treatment of burns.

The new advice given is that when definitive care cannot be carried out within two hours, the patient should receive sufficient morphine to relieve pain (not less than one half grain, except in patients with lung and bronchial damage, the very old or the very young) and the burned surfaces should be covered with sterile boric acid ointment or petrolatum over which one or two layers of gauze of fine mesh (44) is to be applied smoothly.

Over this dressing thick sterile gauze or sterile cotton waste is to be placed and the entire dressing is to be bandaged firmly but not tightly. Substitution of jelly containing 5 per cent sulfathiazole in a water-soluble base, which is supplied in the O.C.D. carrying case A for mobile medical teams, is permissible.

The discussion of definitive treatment of burns has been expanded to stress the necessity for administration of large amounts of plasma.

"In patients with severe burns, quantities up to 12 units or more may be required in the first twenty-four hours," it is pointed out. "To the patient in critical condition, plasma must be given rapidly (as much as 500 cc. in ten minutes may be necessary) and not allowed to flow drop by drop. It must never be administered by any other than the intravenous route. Syringe injection may be used.

"If facilities for hematocrit determinations are available, the following general rule can be used for guidance regarding the amount of plasma required. For each point that the hematocrit is above 50 per cent cells, at least 100 cc. of plasma should be administered. If clinically satisfactory results are not obtained with this dosage, larger quantities should be given."

A footnote points out that rapid administration of intravenous fluids may be dangerous to cardiac disease patients and that the physician's judgment will have to determine both the amount and the rate of administration in such cases.

The pamphlet describes "open" and "closed" treatment for burns. The "open" treatment, which is now considered the treatment of choice and is especially recommended for treatment of burns of the hands, face, feet, perineum and genitalia, consists essentially of the application of boric acid ointment or petrolatum, with pressure dressings. Such dressings can often be left in place twelve or fourteen days.

The "closed" treatment, which is the tanning or eschar method, is particularly indicated in extensive "flash" or second degree burns of the trunk. This method is recommended only if the following conditions are present: (1) if not more than twenty-four hours have elapsed; (2) if the burned area has not been grossly contaminated; (3) if strict surgical asepsis is employed in the preparation of the burned surface, and (4) if coagulation is rapidly accomplished, *i.e.* by combined use of tannic acid and silver nitrate. The method of tanning is described as in the original edition of the pamphlet.

In the new directions, additional emphasis is placed on masking of both the patient and his attendants, in order to minimize the danger of secondary infection.

Use Sulfa Drugs With Care

Recommendations for the use of sulfonamides are accompanied by the observation that these drugs must be used more cautiously in the treatment of civilian wounds than is necessary in the care of military casualties for the following reasons:

"The injured may include individuals of all ages and with various types of preexisting disease. The possibility of toxic effects is, therefore, greatly enhanced. Moreover, it is assumed that in civilian injuries hospitalization will be possible in a relatively short time. This usually makes it possible to postpone all consideration of chemotherapy until the injured have been hospitalized."

In a discussion of intra-abdominal wounds leading to perforation of the hollow viscera, the revised pamphlet advises sodium sulfadiazine as the drug of choice for parenteral administration, which is considered preferable during the first forty-eight hours.

Concentrated solutions of sodium sulfadiazine are not recommended for subcutaneous or intramuscular routes, but it is pointed out that weak solutions (0.5 per cent) may be used with little danger of sloughing of the tissues.

Special emphasis is placed on the danger of giving sulfonamide drugs

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to a patient who is not voiding normally (more than 1000 cc. per day).

"Should circumstances require sulfonamide administration in the presence of inadequate urinary output, the urine should be watched for evidence of renal damage and the drug should be adjusted so that a blood concentration not to exceed 10 mg. per cent is maintained. If further diminution of the urinary output occurs, administration of the drug should be stopped immediately and fluids should be forced, orally or intravenously."

NOTES AND ABSTRACTS

Conducted by the Staff of the Pharmacology Department Wayne University, Detroit

The Hospital and Chemical Warfare

With so many bets being tossed around that the war will end this year or next year, there is the danger of considering it already won. There is the danger of our refusing to take out any more war insurance policies, if one may so refer to precautionary measures against possible attack—measures which the far-sighted individual deems it prudent to take even though, at the time, they appear useless and unduly pessimistic.

That attitude of secure complacence has made it particularly difficult to urge any effective program of defense against hypothetical and seemingly remote gas attacks. Gas has not yet been used on a large scale in the present conflict although it was employed by the Italians against the Ethiopians and has been many times used by the Japanese against the Chinese.

It is worth remarking, for the sake of the record, that, of the great powers in the present conflict, only Japan and the United States have never signed international agreements outlawing the use of poisonous gases. That is, of course, a matter of nice ethical distinction which would obviously be no deterrent to the Nazi.

Because of popular sentiment in this country, it is unlikely that we shall be the first to employ this weapon, despite the fact that it is probably the most humane of modern war weapons. It can cause a high number of casualties with a relatively low percentage of fatalities (an average less than 4 per cent in the last war) and a low percentage of incomplete recoveries. The tremendous number of our troops in the last war that claimed residua after gassing probably erred in attributing to gassing effects that were actually the sequelae of influenza.

It is nonetheless advisable to keep in mind the enormous stores of war gases available for potential use. In the years prior to the present conflict Germany imported manyfold her normal requirements of arsenic, which in peace time is employed largely in insecticides.

It would have been ample for the delousing of all of Europe, "a consummation devoutly to be wished" by anyone who has had the dubious privilege of sleeping in many European beds but a consummation not yet clearly demonstrated. We must, then, to avoid being called Pollyannish, hypothesize other purposes for that arsenic. Unquestionably, it went into arsenical, vesicant war gases.

It is no secret that we have had four plants in this country devoted entirely to the production of war gases. The oldest has been in operation for years, the youngest, for many months. The far-sightedness of our armed forces in

preparing offensively and defensively for gas warfare has been the greatest deterrent against its inception. We must hope that the preparedness of our armed forces continues as an effectual deterrent lest the inception of gas warfare find the abysmally unprepared civilian population unwilling matriculates in the costly school of experience.

Experts have estimated that the casualties among an untrained populace are at least ten times those among a carefully trained group. Despite the heroic efforts of a few diligent and qualified leaders, most civilians are still completely unaware of even the rudimentary precautions necessary for self-protection in a gas attack.

We come to the rôle of the hospital in a hypothetical gas attack, and there are at least some experts who consider it not so highly hypothetical. The hospital should be prepared to render itself relatively airtight so as to prevent the entrance of any gas that might be in its neighborhood. The institution should also take steps to protect its personnel against incoming patients who have been contaminated with a vesicant gas, since anyone who handles a contaminated patient at once becomes a casualty himself. That requires the setup of a cleansing station at the hospital, a procedure carefully described in available government publications.

The cleansing station must be operated by a trained group and that training takes time. Admittedly, time is at a premium among constantly overworked hospital personnel. The price of not taking that time now, however, will be the temporary loss of a crippling percentage of the hospital's personnel should a gas attack ever find it totally unprepared.

"We can learn when the emergency confronts us," is a cliché that has thwarted more than one effort at preparedness. The tuition in that school is too high and the man who insists on paying it is wantonly extravagant.

It is not the purpose of this article to give the directions for setting up a cleansing station; rather is its purpose to remind hospitals again that, as the centers with which progressive medical leadership has always been associated, they must take the first steps if others are to be expected to follow.

It is reasonable for inland hospitals in this country to assume that gas will be used elsewhere before they themselves are exposed to it. The minimal preparation for them should be a carefully prepared skeletal scheme of rapid organization at the sound of the first warning gong, which, presumably, will be a gas attack on one of the fighting fronts.

Hospitals have a second obligation in a preparedness program against hypothetical gas attack. They should aid and stimulate a progressive education of civilians that they may learn how to protect themselves if gas should come. The self-interest of hospitals demands that, lest an attack find their wards so filled with unnecessary civilian gas casualties that they are unable to treat the burned and the wounded.

The first-aid principles for civilians in a gas attack are relatively simple but, if they are to be effective in a crisis, civilians must be drilled in them until they become second nature. Civilians should be taught the following:

1. They must immediately get out of a gassed area by advancing toward the wind;

2. They should seek refuge in a building, which can be made to offer entirely adequate protection against anything but a direct hit if the doors and windows are closed and the larger cracks are plugged with wet blankets or papers. Inasmuch as all effective war gases are heavier than air, people should avoid the basement as the concentration of any gas leaking into the house will be greatest there.

3. If clothing becomes contaminated with liquid it should be immediately discarded and the closest supply of water should be used for thorough washing,

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especially of the eyes. Soap is fine and a chemical cleansing agent is better, but since the cleansing should be undertaken within sixty seconds of contact, neither of these is likely to be too handy.

4. No one should look up during a gas attack lest the eyes become contaminated. Eyes should be shielded, if possible, with the arm and, if they become contaminated, should be washed immediately with copious amounts of warm 1 per cent solution of sodium bicarbonate or with water if the sodium bicarbonate is unavailable.

5. The civilian should be taught that he does not need a gas mask because there is no reason for him to remain in a gassed area. Since the mask protects only the respiratory tract and certain portions of the head, its possession might give the civilian a false sense of security so that he would linger in the gassed area to the point that the rest of his body fell victim to the vesicant.

If hospitals emphasize the program of education for civilians now, they not only will be performing a great service but will have few simple gas casualties to treat during a gas attack and, in an emergency, will be free to treat those unavoidable victims of war agents.—B. N. CRAVER.

CLINICAL BRIEFS

Conducted by E. M. Bluestone, M.D.

Abdominal Adhesions Tested

In 1922, Dr. B. B. Vincent Lyon published a description of a new diagnostic technic which tested the likelihood of adhesions in the upper right abdomen by means of a tuning fork and a stethoscope simultaneously applied to the abdomen.

Doctor Lyon has re-evaluated this test after a study of approximately 85 cases in which the tuning fork evidence was compared with the x-ray evidence of upper right quadrant adhesions and the accuracy of each test was evaluated by actual findings on operation. In his article, "A Test for Abdominal Adhesions," published in the *Annals of Internal Medicine,* March 1943, Doctor Lyon reports agreement in tuning fork and x-ray evidence and in operative findings in 42 cases.

The tuning fork was correct and the x-ray evidence for adhesions was incorrect as reported by the surgeon in 21 cases. The tuning fork was correct and the x-ray evidence was doubtful as proved by the surgeon in 14 cases. The tuning fork was incorrect as proved by the surgeon in eight cases.

The underlying principle of the test is the conduction or transmission of a tuning fork note from (1) one hollow organ to another hollow organ, as from gall bladder to stomach or duodenum, or (2) a solid organ to a hollow organ, *i.e.* from the liver to the colon. This is possible only when two organs are bound to each other by adhesions.

In applying this test caution is required to avoid the error of interpretation in the event that the left lobe of the liver is enlarged. The examiner must avoid stretching the skin between the bell of the stethoscope and the stem of the tuning fork, since this will produce surface conduction of sound.

In the hands of a competent observer this test may help to select cases for surgery more accurately and to prepare for technical difficulties in operations on the upper right quadrant. The presence of adhesions in the upper right quadrant greatly increases technical difficulties of operation.—ABRAHAM JEZER, M.D.

Kenny Treatment Preferred

Sixty patients under treatment from May 1941 to May 1942 at New York Orthopedic Dispensary and Hospital for the acute stage and paralytic symptoms of poliomyelitis are included in a study, "The Kenny Treatment of Infantile Paralysis," reported by Dr. R. Bingham in the July 1943 issue of the *Journal of Bone and Joint Surgery.*

These patients were divided into three groups: (a) those receiving the Kenny treatment only; (b) those receiving the Kenny treatment late in the course of their illness, and (c) those receiving only the older methods of treatment.

The extent of recovery of some patients under the Kenny treatment was so great that, in studying final results, careful judgment had to be used in deciding which of the improvements in the patient's condition were due to the Kenny treatment and which would have followed from a mild abortive attack.

The following conclusions could, however, safely be drawn:

1. Patients receiving the Kenny treatment are more comfortable, have better general health and nutrition, are more receptive to muscle training, have superior morale, require a shorter period of bed rest and hospital care and seem to have less residual paralysis and deformity than bed patients treated with the older conventional methods.

2. Treatment by means of bed rest in a natural position, hot moist packs, passive motion and muscle reeducation as described by Sister Kenny is, therefore, recommended as a method of choice for the acute stage of infantile paralysis. —Sigmund L. Friedman, M.D.

Study of Roentgen Therapy

I studied roentgen therapy of primary cancer of the nasopharynx on the basis of 63 patients treated at the Presbyterian and Montefiore hospitals in New York City. The disease is probably commoner than is generally realized and is especially prevalent among the Chinese.

In my article "Roentgen Therapy of Primary Cancer of the Nasopharynx," in the *American Journal of Roentgenology and Radium Therapy,* December 1942, it was emphasized that cancer of the nasopharynx, unless controlled by radiotherapy, ends in death of the patient. Diagnosis is often late because of the relative rarity of this cancer, its insidious symptomatology and the difficulty of thorough clinical examination, and also because successful biopsy is often interfered with by the tendency of adjacent adenoid tissue to cover up the underlying cancer.

Most patients, therefore, present themselves for treatment with locally extensive disease, at times with extension to the skull and frequently with regional lymph node metastases. The latter often so dominate the early clinical picture that the primary lesion is not recognized and is not treated.

Because of these various reasons operative removal is usually inadequate, especially as surgical approach is difficult.

External roentgen therapy has, so far, been practically the only treatment that has been successful in eradicating the disease.

The bearing that the microscopic structure and extent of the cancer have on the outcome of this treatment is clearly shown: 13 of 44 patients treated more than five years prior to the report are free from clinical evidence of cancer; 11 of the 13 cures occurred among cases classified as lymphoepitheliomas or lymphosarcomas.

Death in most of these two groups was due to distant metastases in contrast to cases classified as cylindromas or epitheliomas, who died because of local persistence or extension to the skull. Other factors influencing prognosis were location of the tumor within the skull, invasion of the skull and involvement of cranial nerves.

The staffs of clinics handling head and neck cases should be aware that cancer of the nasopharynx may masquerade as cervical lymphadenopathy or primary involvement of the fifth, sixth, ninth or tenth cranial or cervical sympathetic nerves.

Careful nasopharyngeal examination, repeated biopsies and radiographic studies, when indicated, of the skull and especially of the body and the wings of the sphenoid are extremely important in order to obviate mistakes. — Maurice Lenz, M.D.

NEWS IN REVIEW

Doctor Shortage to Continue Unless Army Requirements Change, O.W.I. Warns

WASHINGTON, D. C.—The shortage of civilian physicians will continue to grow more acute for some time and perhaps until the end of the war unless the armed forces revise their requirements, according to figures contained in a summary prepared by the Office of War Information and released September 6.

So far the armed forces have commissioned only a little more than 80 per cent of the number of physicians needed and are, therefore, continuing to withdraw physicians from civilian practice. Furthermore, although the accelerated medical education program will make available about 7000 new physicians each year beginning in September 1944, the armed forces will take approximately 80 per cent of them. This will be sufficient to keep up the supply of doctors in the armed forces, but the remaining 1500 new physicians are not enough to replace those who die each year (from 2500 to 3000).

In an attempt to compensate for this shortage, the U.S.P.H.S. and the P. and A. Service are making efforts to achieve the optimum distribution of the doctors remaining for civilian practice. They are making surveys to determine needs, seeking to shift physicians to places with the greatest scarcity, limiting doctor recruitment in such states, helping local authorities to organize cooperative use of doctors and facilities where consent can be obtained, improving and increasing hospital and clinical facilities, continuing to improve sanitary conditions, extending the control of venereal diseases, and carrying on widespread tuberculosis case-finding work through traveling x-ray units of the U.S.P.H.S.

P. and A. has found state medical licensure laws extremely handicapping in attempting to get physicians to shift to areas where they are more needed and in attempting to place foreign doctors licensed by the state of New York. Twenty-eight states require complete citizenship, 14 require first papers, 24 forbid the acceptance of graduates of foreign schools and still others require such graduates to have further education in the United States.

The pool of foreign doctors contains 6000 variously qualified physicians, 2000 of whom have become citizens. They constitute our largest available reserve of physicians. Officials estimate that fully one half of them will return to Europe after the war.

Nursing Schools to Determine Policy in Regard to Marriage

WASHINGTON, D. C.—An applicant, before enrolling in any school of nursing as a U. S. cadet nurse, should understand the school's policy on marriage, announced the Division of Nurse Education, U. S. Public Health Service, September 13. In many schools, marriage does not prevent the admission and retention of students. In some schools, maternity leave is granted. In a few schools married applicants are not admitted and married students are not retained.

If a school admits and retains married students, the "health permitting" clause in the application signed by the cadet nurse allows the school to provide maternity leave. This clause applies in the same fashion to the graduate nurse who has pledged herself to render essential nursing service throughout the war.

for the management of constipation

Habit Time for Bowel Movement in convalescence is decidedly a valuable factor which contributes to the patient's well-being and comfort.

A weakened system, recovering from the ravages of disease, must be aided gently and persistently in the restoration and ultimate maintenance of physiological activity.

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Constant uniformity assures palatability —normal fecal consistency. Five types of Petrogalar provide convenient variability for individual needs.

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Urgent Need for More Graduate Nurses Told by Health Officials

By EVA ADAMS CROSS
Washington Representative, The MODERN HOSPITAL

WASHINGTON, D. C.—Urgent as the appeal for student nurses is, that which has gone out for graduate nurses is even more urgent, said an official of the nursing division, U. S. Public Health Service, in an interview September 10. This view was also indicated by the Procurement and Assignment Service and the Office of War Information. Graduate nurses are needed to train as teachers and for duties in other important fields, particularly in industrial nursing and venereal disease nursing. Hospitals, nursing schools and public health nursing agencies are urged to encourage promising members of their staffs or their new graduates to avail themselves of postgraduate opportunities.

The Bolton Act provides funds for advanced training in preparation for nursing service positions, including vital administrative and teaching functions, work in clinical fields, public health nursing organizations and hospitals. Funds are allocated to train nurses for faculty positions in institutions offering basic or advanced nursing curriculums. These postgraduate programs may lead to a degree or they may be realigned and modified to meet war-time demands.

Far from being able to cope with any widespread illness, many American hospitals cannot maintain even normal standards of service because of the lack of nurses, the Office of War Information reported August 24. While more and more skilled nurses are being drawn into military service and industry, the number of admissions to hospitals is increasing.

There are now slightly more than 250,000 nurses serving on the home front, the report continues. A year hence America will need 359,000—or 100,000 more than are now available. Of this number 66,000 will be needed for the military services and 293,000 for civilians. Only 65,000 can be trained within that period. America will still be short 35,000 nurses.

Five definite steps are being taken by P. and A. to meet the serious discrepancy between supply and demand for nursing service. The first step is to meet the requirements of the armed forces. They have priority over all others. More than 36,000 nurses are already serving in the various branches of the military services. The American Red Cross will recruit another 36,000 by June 30, 1944.

The second step will be the effort to bring back into service the thousands of registered nurses who have left the profession because of marriage or other occupations. The recruiting of more Red Cross nurses' aides to augment the 72,960 certified and the 100,000 enrolled in classes on June 1 will be a third step in the campaign.

An educational program to bring about a better conservation and utilization of nurses is the fourth step. The fifth aims at meeting the nation's increasing need for more nurses. This involves developing and maintaining a roster of all graduate registered nurses in the nation.

Red Cross Discusses Recruiting

WASHINGTON, D. C.—Plans for recruitment of nurses were discussed at the conference of nursing administrators and field staff representatives held at Eastern Area Headquarters of the American Red Cross in Alexandria August 24. Speakers at the meeting were Capt. Sue Dauser, superintendent, Navy Nurse Corps, Capt. Kathleen Atto, Army Nurse Corps, Louise Baker, assistant executive officer, Procurement and Assignment Service in charge of nursing service, War Manpower Commission, and Gertrude Banfield, assistant director of nursing, American Red Cross. Some 30 representatives from the Eastern states attended the conference.

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COUNTLESS cases of hospitalized pruritus and decubitus have been given prolonged relief by the soothing, analgesic action of ***NUPERCAINAL****.

An ointment containing ***NUPERCAINE****— non-narcotic local anesthetic — ***NUPERCAINAL*** brings quick and long-lasting comfort to ulcerated and inflamed conditions of the skin and mucous membranes.

For hospital use ***NUPERCAINAL*** is supplied in jars of one pound. Also available in one-ounce tubes with rectal tip.

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SUMMIT, NEW JERSEY

Army Examinations for the Medical Corps Will Be Held in January

WASHINGTON, D. C.—Examinations will be held January 24 to 27 for candidates who wish to qualify as first lieutenants in the medical corps of the regular Army to fill vacancies occurring during the fiscal year, 1945, the War Department announced September 8. The examinations are open to all male citizens of the United States provided they are graduates of acceptable medical schools in the United States and Canada and have completed one year's internship in an approved hospital and will not be more than 32 years old by the time they are tendered a commission.

The examinations will be conducted by boards of medical department officers. If a candidate fails the examination, he will be permitted to take only one subsequent examination. The examinations will consist of a physical examination, a written examination in professional subjects and a determination of the candidate's adaptability for military service. Full information will be furnished upon request by the Adjutant General, War Department, Washington 25, D. C.

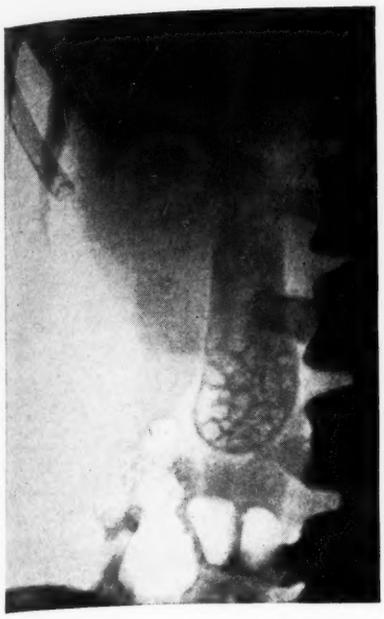
The ninth class of medical inspectors, consisting of 43 officers of the Medical Department, was graduated September 3 after a special one month training course at the Medical Field Service School, Carlisle Barracks, Pa.

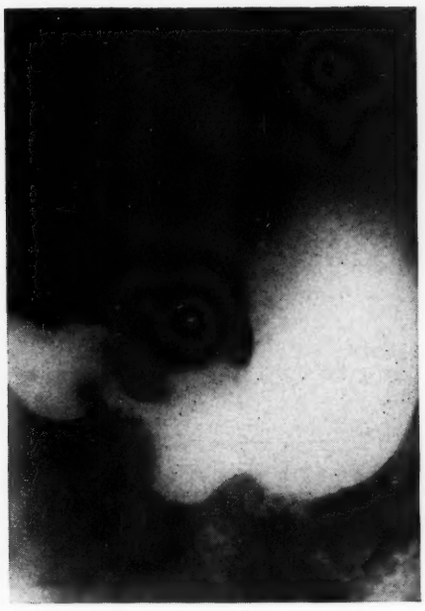
Six Dispensary Units Set Up

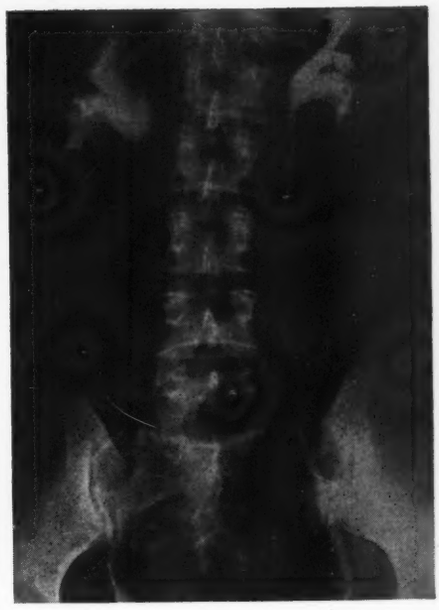
WASHINGTON, D. C.—Six new independent dispensary hospital units have been completed at six auxiliary air fields in Florida, according to an announcement of the Bureau of Surgery August 28. Each sick bay will contain ward facilities for 42 patients. Each unit will be provided with portable x-ray equipment, complete laboratory facilities, flight surgeons' instruments, darkroom and examining room, as well as the regular medical, surgical and pharmacy facilities. Three medical and two dental officers are to be assigned to each of these units.

Cadet Corps Approves New Schools

WASHINGTON, D. C.—The Nurse Education Division, U.S.P.H.S., announced on September 16 that well over 1000 schools have applied for approval under the U. S. Cadet Nurse Corps program and of that number 500 have already been approved. Allotments totaling some $27,500,000 have been made to these accredited nursing schools and approximately 51,589 student nurses will thus get free training in professional nursing. Of this number, 27,258 are second and third year student nurses and 24,331 are new recruits.







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Because of the meticulous care with which they are manufactured, and the rigid laboratory control to which they are subjected, Merck radiopaque preparations are dependable aids in making a diagnosis.

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IODOPHTHALEIN SODIUM MERCK

Disodium salt of tetraiodophenolphthalein.

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3.5 Gm., 25 Gm., 100 Gm., 500 Gm.

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Special barium sulfate preparation containing tragacanth.

NOTE: Two forms are available:
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Special barium sulfate cream which ensures stable suspensions.

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BOTTLES
1 oz., ¼ lb., 1 lb., 5 lb.

MERCK & CO., Inc. *Manufacturing Chemists* RAHWAY, N. J.

Quick Action Promised on School Housing for Cadets

(*Continued from page* 49)

Institutions that do not require F.W.A. assistance should make application for priorities assistance directly to W.P.B. at Washington on Form WPB 617. WPB 2814.1 will accompany WPB 617. In the "hospital section" of WPB 2814.1, only questions pertinent to the applicant hospital need be answered. In the "nurses' home" section, all questions must be answered.

Mr. Maverick advises that when applications for additional facilities are submitted to his office, they must be accompanied by a statement from the U.S.P.H.S. This will certify that the applicant is a participant in the cadet nurse corps training program, that the facilities requested are essential and will give the number of additional students approved for training.

For convenience in making preliminary requests for Lanham Act assistance, the accompanying list is presented, giving the names of regional F.W.A. directors and the states under their respective jurisdiction. It appears in the column to the right.

WHERE TO APPLY FOR FUNDS

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John M. Gallagher, 101 Park Avenue, New York 17, N. Y.	N. Y., N. J., Pa.
James A. McConnell, 99 Clancy Street, Boston 11.	Me., N. H., Vt., Mass., Conn., R.I.
Kenneth Markwell, 904 East Main Street, Richmond 19, Va.	Md., Del., D. C., Va., W. Va., N.C.
Oliver T. Ray, 20 Fifth Street, Atlanta, Ga.	Tenn., S. C., Miss., Ala., Ga., Fla., P. R.
Lawrence A. Gillett, 20 North Wacker Drive, Chicago 6.	Wis., Ill., Ohio, Mich., Ky., Ind.
James W. Bradner Jr., 710 Electric Bldg., Ft. Worth 2, Tex.	Tex., Okla., Ark., La.
C. W. Anderson, City Hall, St. Paul 2, Minn.	Minn., N. D., S. D., Ia., Kan., Neb., Mo.
Rex Nicholson, 2223 Fulton Street, Berkeley, Calif.	Wash., Ore., Calif., Mont., Ida., Nev., Colo., Utah, Ariz., N.M., Wyo., T. H.

Can Deduct Hospital Payments

Insurance companies may deduct group hospitalization payments in calculating net income. This ruling obtains under order of the Treasury Department and the War Labor Board to the effect that "premium payments by an employer for group hospitalization benefits for its employes constitute deductions under the head of ordinary and necessary business expenses in computing the net income of an employer."

Polio Cases Highest Since 1934

An analysis of the first twenty-six weeks of this year shows the total number of cases of infantile paralysis to be higher than for any of the last twelve years except 1934. Cases reported for the first six months totaled 1084 from 42 states, whereas the six months' average for the last ten years is 841. To date, the states most severely affected are California, Texas and Oklahoma. Their totals are 351,230 and 33 cases, respectively.

Reimbursement Rate Raised

Reimbursement to casualty receiving and emergency base hospitals by the U. S. Public Health Service for the care of civilian war casualites has been increased to $4.25 per day. The hospital section of the medical division of the Office of Civilian Defense is responsible for preparations for the hospitalization of civilian war casualties and of patients in civilian hospitals which must be evacuated.

New STEAM TABLE CHART SHOWS HOW TO SAVE FOOD, FUEL and IMPROVE SERVICE

The Robertshaw thermostats on your steam tables, if operated correctly, can do a lot to make up for inexperienced employees you may have to depend upon. They were made and installed to prevent the mistakes caused by inexperience.

These mistakes cost money and hurt your business. For example, if the steam tables are too hot, fuel is wasted and food is over-cooked. And if they're not hot enough, the food is chilled by the time it reaches the table. In either case customers are dissatisfied.

This new instruction chart will show how to prevent this. It is one of a set of five offered to you for only twenty-five cents the set — just enough to cover printing and mailing costs. Set also includes charts for roasting and bake ovens, deep fat fryers, coffee urns. Each chart is 10″ x 15″, printed in two colors on durable cardboard. Send for your set today, using the handy coupon below.

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30 Church St., New York 7, N. Y.

Please send me the set of five instruction charts to help me teach inexperienced employees how to save food and fuel. I enclose twenty-five cents to cover printing and mailing costs.

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F.S.A. Sets Up Vocational Rehabilitation Office for Disabled Civilians

WASHINGTON, D. C.—Hospitals will play an important part in the expanded federal-state civilian rehabilitation program provided under the Barden-LaFollette Act of July 6, 1943, said Mary Switzer, assistant to the Federal Security Administrator, in an interview with the Washington representative of The MODERN HOSPITAL September 9. Physical restoration will be emphasized, she explained, calling attention to Mr. McNutt's statement of the preceding day that reemployment of the physically handicapped would be facilitated through provisions for physical restoration where possible.

Though until now the program did not provide for remedial treatment, provisions in the Barden-LaFollette Act, Miss Switzer pointed out, stress the fact that the new law makes federal money available for surgery, therapeutic treatment, hospitalization and medical examination.

To administer this expanded program a new Office of Vocational Rehabilitation in the Federal Security Agency has been set up, according to an announcement September 8 by Federal Security Administrator Paul V. McNutt. The new legislation meets a special war-time need by providing for the vocational rehabilitation of persons injured in nonmilitary war services.

As a war measure, the federal government will pay the expenses incurred by the states in the rehabilitation of these war-disabled civilians. Under the new statute federal grants also cover the entire administrative cost of approved state vocational rehabilitation programs and half the expense for rehabilitating individuals other than war-disabled civilians.

Earlier Mr. McNutt had announced that every effort was being made to rehabilitate men discharged from the armed services because of disabilities so that they could get into useful employment. Service in 309 Army and Navy hospitals is now provided by the veterans' employment division of the United States Employment Service. This gives veterans a direct contact with the veterans' employment representative in their home towns, their first step on the way back to a civilian job. Training is available for those with service-connected disabilities.

Chile Plans Vast Program of New Hospital Construction

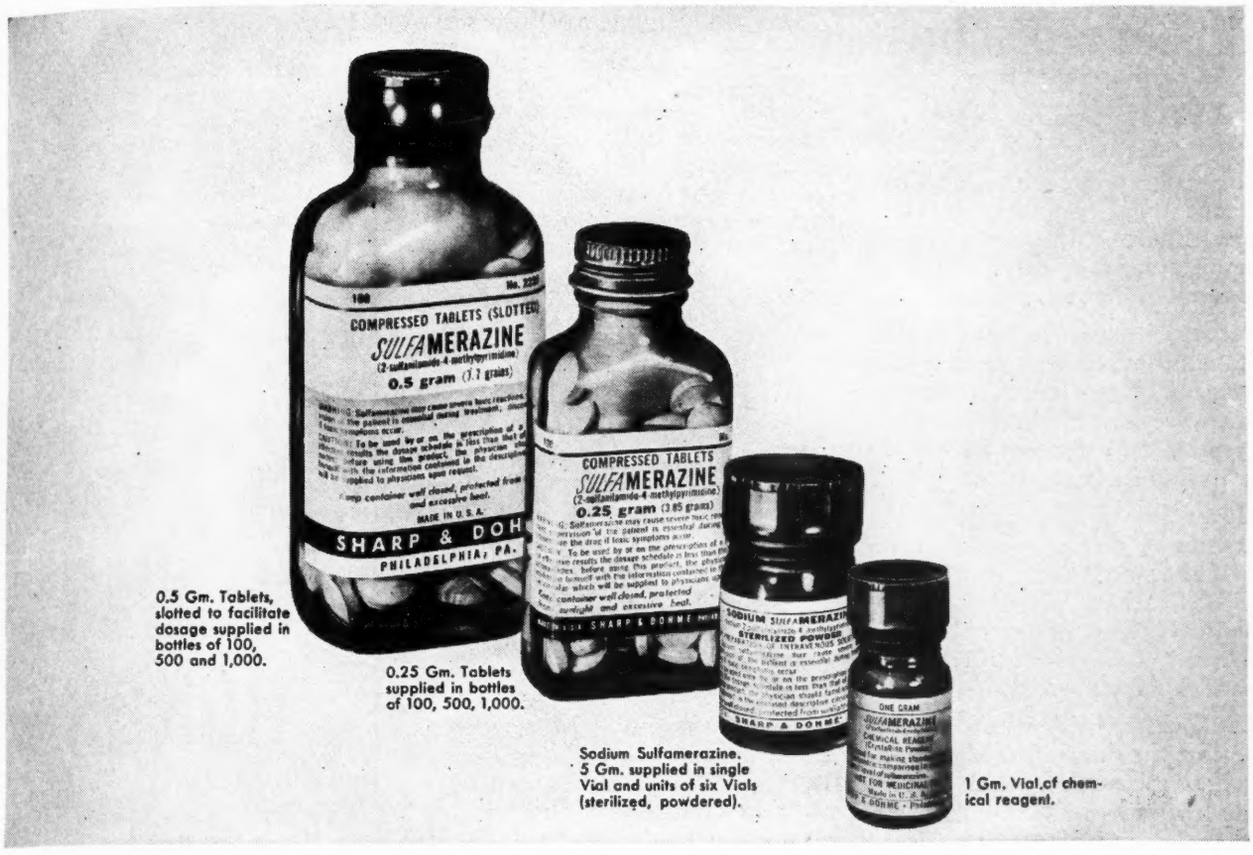
CHILE (Special Correspondence)—A vast increase in Chilean hospital facilities has recently been announced by that government. A total of 356,000,000 pesos, approximately $16,500,000 in United States currency, has been designated for "urgent" and "extremely urgent" hospital projects.

The expenditure comes in answer to a recent survey showing that only 25 per cent of the country's hospitals are equipped to receive patients properly; only 16 per cent provide permanent emergency and accident services, and only 25 per cent are equipped for specialized medical, surgical and obstetric services.

Building of the "extremely urgent" type will be carried out in the following communities: Antofagasta, La Serena, Chanaral, Quillota, Temuco, Traiguen, Achao, Punta Arenas, Ancud and Santiago. It is stated that the entire program will place Chile among the American republics possessing complete medical facilities.

Medical Librarians' School Opened

The opening of a training school for medical research librarians has been announced by Manhattan General Hospital, New York City. The training period will be ten months, followed by a two months' internship.



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SIMPLIFIED • ECONOMICAL • SULFONAMIDE THERAPY

• *The Medical-Research Laboratories of Sharp & Dohme have developed a new compound which will simplify dosage and lower costs in sulfonamide therapy. This remarkable product is called SULFAMERAZINE. Its chemical designation is 2-sulfanilamido-4-methylpyrimidine (methylsulfadiazine).*

In comparison with sulfadiazine, sulfamerazine is more rapidly and completely absorbed from the gastro-intestinal tract and more slowly eliminated by the kidneys. Thus, smaller or less frequent doses of sulfamerazine are necessary to produce and maintain therapeutic concentrations of the drug in the blood and tissues.

Moreover, free and acetylated sulfamerazine are slightly more soluble in neutral or acid urine than are the corresponding forms of sulfadiazine.

For these reasons, the possibility of drug concretions in the urinary tract should be less with sulfamerazine.

The less frequently required doses of sulfamerazine reduce sulfonamide therapy to more economical terms. In diseases in which four to six doses of sulfadiazine (or other sulfonamide) are given daily, the same therapeutic results may be obtained with a minimum of inconvenience to the patient and at proportionately lower cost.

• • •

Sulfamerazine tablets are administered by mouth in the treatment of infections caused by pneumococci, streptococci, meningococci and gonococci. Solutions of sodium sulfamerazine are given intravenously.

Moreover, the smaller effective dose and longer retention of sulfamerazine have suggested the new drug's value as a prophylactic against certain infections such as rheumatic fever and gonorrhea. It is no more toxic than sulfadiazine and appears to be even safer, especially with regard to the possibility of urinary complications.

Detailed information may be obtained upon request from the Medical-Research Division, Sharp & Dohme, Philadelphia (1), Pa.

SULFAMERAZINE

33 New Hospitals Completed on July 31, O.W.I. Discloses

By EVA ADAMS CROSS
Washington Representative, The MODERN HOSPITAL

WASHINGTON, D. C.—According to an O.W.I. report dated September 6, the Federal Works Agency lists 33 new hospitals as wholly or substantially completed as of July 31, at an estimated cost of $4,265,513, of which the government allotted $3,481,435. These hospitals will supply an additional 1615 beds for civilian use.

Hospitals for which funds have been allotted—some under construction, some on which contracts have been awarded and some on which bids have been asked—total 250 and will cost $53,451,136, of which the government is paying $44,702,052. An additional 13,827 beds for civilian care will thus be provided. Of health centers, usually providing clinics and 6 to 8 emergency beds each, 44 had been completed as of June 15, 1943.

Among other projects financed through F.W.A. as war public works and services, including a great number already finished and others approved by the President, as of June 30, are 489 hospitals, venereal disease hospitals and health centers, the estimated cost of which totals $72,385,054 of which the government furnished $62,845,973.

The U. S. Public Health Service has recommended 451 health centers and hospital projects. As of Feb. 15, 1943, 358 had been recommended and approved and 153 had been constructed or were in process of building.

On September 8 the Federal Works Agency reported the following construction:

In Pittsburg, Calif., a 52 bed hospital building; a 25 bed nurses' home. The estimated cost is $434,600.

In St. Paul, Minn., a nurses' home. The estimated cost for the purchase, renovation and equipment of an existing building for use as quarters for 34 student nurses is $40,170. The basic justification for this project is the training of additional nurses to supply the armed forces and civilian need. The applicant is Charles T. Miller Hospital, Inc., which is affiliated with the University of Minnesota School of Nursing and Minneapolis General Hospital.

In Milwaukee, an addition to and alterations of the Columbia Hospital to provide improved kitchen and other food service facilities and an out-patient department. The estimated cost is $112,000.

Will Ross Given Award

The Hoyt E. Dearholt memorial award for outstanding work in the tuberculosis field in 1942 has been awarded to Will Ross of Milwaukee, a director of the National Tuberculosis Association and head of Will Ross, Inc., hospital supply manufacturers. The presentation was made in connection with the thirtieth annual Mississippi Valley Conference on Tuberculosis.

U.S.P.H.S. Reports on National Health After Nearly Two Years of War

By EVA ADAMS CROSS
Washington Representative, The MODERN HOSPITAL

A fairly optimistic note so far as the home health front is concerned is struck in a report of the U. S. Public Health Service dated August 20. A short study, it says in part:

"Emergency conditions and the various restrictions which have been imposed upon the American people as the result of the war have not as yet seriously affected the public health.

"It has now been more than a year and a half since the United States entered the conflict. During the first year of our participation, 1942, the death rate for the United States was the lowest ever recorded (10.4 per 1000 population), and only one important communicable disease, meningococcus meningitis, assumed epidemic proportions. Typhoid fever and smallpox established new low records during the year." The death rate from tuberculosis has been lower, declares the U.S.P.H.S. report, than in 1939 and 1940.

The high health level of 1942 has been maintained during the first half of 1943, the report continues. With the exception of meningococcus meningitis, poliomyelitis and the dysenteries, the incidence of the communicable diseases reported to the Public Health Service during the first half, even the first seven months, of 1943 is below or approximately the same as that for the corresponding period of 1942.

The incidence of these two diseases, and the dysenteries has exceeded normal expectancy. But preliminary figures indicate a new low record in 1943 for typhoid morbidity and mortality and possibly for smallpox.

The study concludes with the statement that such a record is a challenge to all health workers to maintain it in the future. "And to do so will undoubtedly require even greater effort in view of the possibilities of epidemics, effects of fatigue in industries running in high gear, malnutrition as the result of lack of the application of knowledge regarding adequate food substitutes, the introduction of tropical diseases by returning troops, the depletion of medical and nursing services for the civilian population and numerous other factors in our social life which adversely affect the health of the people."

Robert Fischelis Honored

WASHINGTON, D. C.—Robert P. Fischelis, chief of the Civilian Requirements Branch, W.P.B., has been awarded the Remington Honor Medal, according to an announcement September 3. The medal is conferred each year by the New York branch of the American Pharmaceutical Association for the man or woman who has done the most for American pharmacy during the preceding year or during a longer period of outstanding activity and fruitful achievement. Mr. Fischelis is chairman of the council of the American Pharmaceutical Association and president of the New Jersey Pharmaceutical Association. He is a member of the revision committee of the United States Pharmacopeia and was pharmacy's representative at the National Health Conference called by President Roosevelt in 1938.

Druggists Send Quinine to War

WASHINGTON, D. C.—More than 11,000,000 5-grain doses of quinine are on their way to war against malaria with the compliments of the nation's druggists, the Navy Department announced September 5. The National Quinine Pool is sponsored jointly by the Defense Supplies Corporation, War Production Board and the American Pharmaceutical Association. The drive for the pool, launched seven months ago with a goal of 100,000 ounces, has passed that mark by nearly 50 per cent.

OFFICIAL ORDERS
August 15 to September 15

Civilian Requirements.—W.P.B. on September 9 issued a directive designating a specified percentage of the production of a considerable list of items for distribution to civilian consumers through customary distribution channels. The percentages were not announced.

The goods affected include the following of interest to hospitals: glass cooking utensils, bed springs and innerspring mattresses, metal hospital beds, plated silverware, common and safety pins, office supplies, cutlery, electrical physical therapy apparatus, x-ray apparatus and tubes, surgical and medical instruments and equipment, dental instruments and equipment, dental supplies and appliances, ophthalmic goods, surgical and medical supplies and orthopedic appliances, fiber, steel and wire brushes, cast iron boilers and radiators, hot water equipment and heaters and tanks, metal insect screen cloth.

Deliveries.—The restrictions on wholesale and retail motor truck deliveries that have been in effect in 12 eastern states and the District of Columbia since last spring will on October 11 become effective for the nation as a whole. Wholesale deliveries of fresh or frozen meat, poultry, eggs, fruits, vegetables and fish cannot exceed five per week and bread, perishable bakery products and dairy products cannot be delivered more often than six times per week. Ice cream and ices are restricted to four deliveries and ice to seven. Cut flowers have five deliveries.

Electrical Distribution Equipment. — General limitation order L-315, issued on September 16, limited the use of scarce metals in the manufacture of this equipment and limited purchase orders to those with AA-5 or higher ratings.

Fire Protective Equipment. — Further restrictions have been placed on the manufacture and distribution of certain fire protective, signal and alarm equipment, in the amendment August 23 of Order L-39 by W.P.B. The liberalization of the order concerning the distribution of electrically or pneumatically controlled fire sprinkler equipment cannot benefit hospitals inasmuch as it applies only in aircraft assembly plants, protection of explosives and the like. Control over the sale and delivery of signal and alarm equipment and air raid warning devices was made more restrictive. Application for specific authorization of purchase orders must be made on Form WPB-1319 (formerly PD-556). A detailed description of the equipment must be given; the name of the manufacturer from whom it is purchased, and full information as to why the equipment is needed. And the application may be filed only by the person who is to receive the equipment, not by the supplier. Provisions governing the manufacture and distribution of fire hose now cover new or used linen or flax tow hose as well as cotton rubber-lined hose. Required ratings of purchase orders for fire sprinkler systems and fire hose are raised from A-9 to AA-5.

Fuel Oil.—Heating oil rations for the coming winter will be granted to consumers using less than 10,000 gallons of fuel oil regardless of whether their heating equipment can be converted to coal, O.P.A. announced August 24.

Milk.—To help assure production of manufactured dairy products, W.F.A. on September 8 authorized its director of food distribution to regulate fluid milk sales through a system of dealer quotas. Quotas will probably be established first in large cities. Details of the program may vary in each area. The director is authorized to fix separate quotas for various classes of purchasers. Sales to the armed forces and designated governmental agencies will be quota-exempt.

Pins, Safety and Common.—The situation in regard to the supply of safety pins both for bulk hospital purchases and bandage purchases has been relieved in a satisfactory manner, an official of the Consumers' Durable Goods Division stated on August 21.

The three leading manufacturers of safety pins advise that substantial shipments have been made to civilian hospital requirements during the last half of the second quarter and thus far during the third quarter. In fact, during the month of July one manufacturer shipped 100,000 gross into civilian hospital channels. Concerning the plating of common pins, the official said, "We are now working with the manufacturers and with the copper and tin people to determine whether it is advisable to make brass pins for certain purposes; or whether it is possible to plate in a way that will be rust-resistant under the extreme services imposed by hospitals."

Plumbing and Heating.—The preference rating assigned for repair and replacement of plumbing and heating equipment was raised to AA-5 from A-10 by W.P.B. on August 23. The revised order requires a certification of need by the ultimate consumer for purchase of plumbing and heating equipment or parts costing more than $5. Previous restrictions required certification only when cost of equipment was $50 or more. The ratings authorized by CMP Regulation 5 or 5A may be used for plumbing and heating repairs and maintenance only by those industries listed in Schedules 1 and 11 of that regulation. Accordingly, the AA-1 rating is acceptable for hospitals.

Sheeting, Crib.—Baby pants and crib sheeting made from fabrics coated with vinyl resins probably cannot be made in larger quantities for a few months, W.P.B. announced September 8. But by December there should be adequate supplies for essential civilian requirements, an official said. Vinyl resins have made a rubber substitute superior in many instances to rubber itself.

Springs, Beds.—Guaranteeing an ample supply of bed springs for nurses' homes, the amendment to Order L-49, August 27, gave permission to use rail steel angles and Bessemer or low carbon steel for frames and borders in the manufacture of coil, flat and fabric bed springs.

Plan to Expand Social Security

WASHINGTON, D. C.—While the A.H.A. was in session in Buffalo, President Roosevelt conferred with high fiscal officials on an extension of the social security program as a means of mopping up excess purchasing power and thus curbing inflation. The plan is, apparently, to increase social security taxes by $6,000,000,000, from the present $1,289,000,000 to $7,300,000,000. Such a plan would doubtless include hospital and perhaps medical care.

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No, you don't have to ferret out those essential facts which alone enable you to gauge sheet quality. Not, at least, when you examine Pacific Balanced Sheets.

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PACIFIC *Balanced* SHEETS

Hospital Pharmacists Seek to Standardize Pharmacy Interships

Hospital pharmacy internships will be standardized and approved on a national basis if the desires of the newly formed American Society of Hospital Pharmacists are carried out. The society, holding its second annual convention in Columbus, Ohio, in conjunction with the convention of the American Pharmaceutical Association, adopted a resolution on this subject and invited the cooperation of the American Hospital Association, the American Medical Association, the American College of Surgeons and the American Pharmaceutical Association.

The society is a component part of the A.Ph.A. and, therefore, can only take action of this kind with the approval of the parent body.

As yet the council has not released the official text of the resolution. The essential points were that the internship should be one year in length; that it should be in hospitals approved by the American College of Surgeons and approved for internship or residency by the A.M.A.; that the standards should be substantially those adopted for hospital pharmacies by the A.C.S.; that the actual work should be carried on cooperatively by the A.S.H.P., A.C.S., A.M.A., A.H.A. and A.Ph.A. and perhaps other interested organizations, and that an approved hospital internship should be recognized by state licensing boards as the practical experience required for registration.

Robert P. Fischelis, secretary of the New Jersey Board of Pharmacy, explained to the hospital pharmacists that his board would at present give only one half of the credit for experience in a hospital pharmacy that it gives for experience in a retail drugstore since the hospital pharmacist does not obtain the same kind of commercial experience that is available in the commercial pharmacy.

Mr. Fischelis suggested that hospital pharmacists should set up a qualifying body similar to the A.C.H.A. or the specialty boards to give recognition to persons of established competence in hospital pharmacy.

A challenge to hospital pharmacists to improve their educational qualifications was given by Hazel Landeen of Minneapolis, secretary of the A.S.H.P.

"We must redefine hospital pharmacy, take stock of our institutions and then set about on a systematic program to improve them. We must determine whether we are really educated or merely literate. The real test of a liberal professional education is the ability to accept new viewpoints. We hospital pharmacists have made all too few original contributions to knowledge in our field."

A comprehensive discussion of the content of the hospital pharmacy internship was presented by Evelyn Gray Scott, St. Luke's Hospital, Cleveland.

The rule granting only one half credit toward registration for work taken in a hospital pharmacy works a particular hardship on the nuns who are pharmacists, according to Dr. Edward J. Ireland, dean of the college of pharmacy of Loyola University of the South, New Orleans. It is impossible for Catholic Sisters to work in a commercial pharmacy, Doctor Ireland states. As a result some state boards have made exceptions in their favor.

Before hospitals accept pharmacy graduates for internships, they should send to the school of pharmacy and obtain a transcript of the student's record. "Sometimes good schools graduate students who would not make good pharmacy interns," Doctor Ireland warned.

A resolution is to be submitted to the members of the A.S.H.P. which will permit the acceptance as an associate member of any pharmacist who is a member of the A.Ph.A. and is interested in hospital pharmacy but is not actually a hospital pharmacist.

Another change would permit the A.S.H.P. to remit to a recognized state or regional hospital pharmacists' asso-

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ciation $1 of the $3 dues of any member of that organization. Thus, a single payment of $3 dues would, for example, pay all the dues required by the Cleveland Society of Hospital Pharmacists, the Ohio Society of Hospital Pharmacists and the American Society of Hospital Pharmacists, each organization receiving $1. The member would also have to pay his dues in the A.Ph.A., however, which are from $5 to $7.

Harvey A. K. Whitney, chief pharmacist of the University of Michigan Hospital, Ann Arbor, and chairman of the A.S.H.P., was unable to attend because of illness. His place was taken by his assistant, Don C. Francke. Mr. Francke was thereupon nominated as chairman for the coming year. Other officers nominated were Hazel Landeen, vice chairman; I. T. Reamer of Duke University Hospital, Durham, N. C., secretary, and Sister Mary John, Mercy Hospital, Toledo, Ohio, treasurer. Vote will be taken by mail ballot.

Tuberculosis Directory Published

The new "Directory of Tuberculosis Clinics," published annually by the New York Tuberculosis and Health Association, is just off the press. Among other things, the directory announces that 42 tuberculosis clinics are now operating in New York City. Identifying information is provided on the 26 officially designated district clinics and the 17 non-district clinics which serve New York City's five boroughs.

Included in the directory are maps showing the boundaries for the tuberculosis district clinics and lists of the branch offices of the department of health and district health centers.

Northwestern Offers Special Courses in Hospital Administration

Hospital administration was added to the curriculum of Northwestern University with the opening of the fall semester on September 22. The new program of special courses, leading to the degree of bachelor of science in hospital administration, or Master of Hospital Administration, will be conducted in the school of commerce in Chicago.

Dr. Malcolm T. MacEachern is the director of the course, with Dr. Margaret Du Bois as coordinator and educational adviser and Laura Jackson as assistant to the director. The faculty will include active administrators, heads of special departments in hospitals and other authorities who are thoroughly acquainted with hospital administration.

The two courses that are being offered in the first semester are "History and Development of Hospitals" and "Hospital Organization and Management." During the second semester, the courses offered will include "Personnel Management in Hospitals and Allied Institutions" and "Business Management of Hospitals and Allied Institutions."

Undergraduates of acceptable standing will be admitted as special students who may qualify for the bachelor of science degree by following a prescribed program. Graduate students who have the proper prerequisites may, by taking two hospital administration courses and one other course each semester for three semesters, and one hospital administration course and two other courses in the fourth semester, qualify for the master's degree in two years of evening study, provided they are already administrators or assistants or can take hospital internships concurrently.

Neither the bachelor's or master's degree will be awarded until the candidate has satisfactorily completed a year's administrative internship under the supervision of an acceptable experienced administrator.

Because the announcement of the course was somewhat delayed, university authorities have made arrangements to accept late registrants.

British and American Military Hospitals Pool Doctors and Patients

The work of British and American medical officers is so closely interwoven that there is a complete exchange of staff and patients between institutions operated by the two nations in Great Britain.

"When a British doctor spends a month in an American hospital, or an American eye specialist works in a British hospital, they are not merely observers. They take over the full responsibility of the men they replace," explains Lt. Col. John Douglas of the British War Office.

At an American hospital turned over to the U. S. Army by the British government through reverse lend-lease agreement, more than 50 per cent of its present patients are British. Recently, it received a whole convoy of wounded from North Africa irrespective of nationality. This hospital was originally built by the British Ministry of Health for bomb victims who never materialized. When it was turned over to the U. S. Army last winter, it had been enlarged from a 600 bed to a 1000 bed hospital by the addition of Nissen hut wards.

The British War Office has started fortnightly tours of inspection of the British and American hospitals for officers of both armies.

La Guardia Aids Hospitals in Fight on Milk Price Ceiling

A strong protest was made by the Joint Purchasing Corporation of New York City to the Office of Price Administration because of a recent O.P.A. ruling that voluntary hospitals could be charged ¾ of a cent per quart more for their milk than the ceiling price established for "government agencies and subdivisions thereof."

Coming to the aid of voluntary hospitals, Mayor F. H. La Guardia wrote to the regional administrator of O.P.A. endorsing the purchasing corporation's appeal. Mayor La Guardia stated:

"Most of the voluntary hospitals in New York City receive money from the city treasury in payment of the care of charity patients, and if the City of New York finds it necessary to economize in times like these, this is certainly true of the voluntary hospitals. . . . I wish to join in this appeal for the simple reason that the present regulation certainly constitutes unfair discrimination against these voluntary agencies."

In answer to the arguments presented, the O.P.A. suggested that some modification of the price ceiling order could be made if it could be proved that the institutions as a group were paying no such premium for their supplies as the ¾ of a cent per quart figure.

Psychiatric Rehabilitation Program Started in New York

A psychiatric rehabilitation program aimed at reclaiming some of the 80,000 New York City men thus far rejected or discharged from military service because of mental illness has been launched by the New York Hospital Payne Whitney Psychiatric Clinic. It is said to be the first such project for servicemen in a private hospital in the metropolitan area and is attracting the interest of state selective service officials and social agencies.

The integration of psychiatric treatment with the psychological testing, retraining and employment resources of the community is being emphasized. The program is under the direction of its originator, Dr. Thomas A. C. Rennie, attending psychiatrist at the Payne Whitney Clinic, and Mrs. Melly Simon, chief of psychiatric social service.

Doctor Rennie was recently named director of the division of rehabilitation of the National Committee on Mental Hygiene. Funds to start the clinic were granted by the Commonwealth Fund.

Maine Group Discusses Ways of Preserving Standards in War

The annual meeting of the Maine Hospital Association was held at the Mayflower Hill Campus of Colby College at Waterville September 3 and 4. There were 133 registrations.

Following an informal dinner at the Elmwood Hotel for members of the association Friday evening, a public meeting was held at which Julius S. Bixler, president of Colby College, gave the address of welcome, speaking on the value of a liberal education as a means of teaching practical living. Dr. E. M. Bluestone, director of Montefiore Hospital, New York City, gave an address on "Hospital Progress in War Time."

An innovation of this year's meeting was a series of instructional conferences on such subjects as nursing education, trustee problems, women's auxiliaries, purchasing and hospital diets in war time. Ninety-one attended the conferences, indicating the interest shown in this type of program.

The general theme of the two day session was "The Preservation of Hospital Standards During the War," which was discussed in a symposium covering administration, trustee responsibility, nursing service and professional staff. A second symposium was on new trends in nursing education.

Among the resolutions passed were those pertaining to increasing facilities for nursing education, opposing legislation endangering the voluntary hospital system and instructing the association's delegate to vote for measures calculated to strengthen the American Hospital Association.

The following officers were elected for 1943-44: Frederick T. Hill, M.D., Thayer Hospital, Waterville, president; Joelle C. Hiebert, M.D., Central Maine General Hospital, Lewiston, vice president; Pearl R. Fisher, R.N., Thayer Hospital, Waterville, secretary-treasurer, and Allan Craig, M.D., Eastern Maine General Hospital, Bangor, and T. F. Spear, Rumford Community Hospital, Rumford, executive committee.

National Nursing Council Will Aid Cadet Nurse Program

The U. S. Public Health Service has contracted with the National Nursing Council for War Service for the services of staff members to answer inquiries from prospective students, give public information assistance and organize a college field program. Additional space has been rented to house the expanded clearing bureau and the new college field unit.

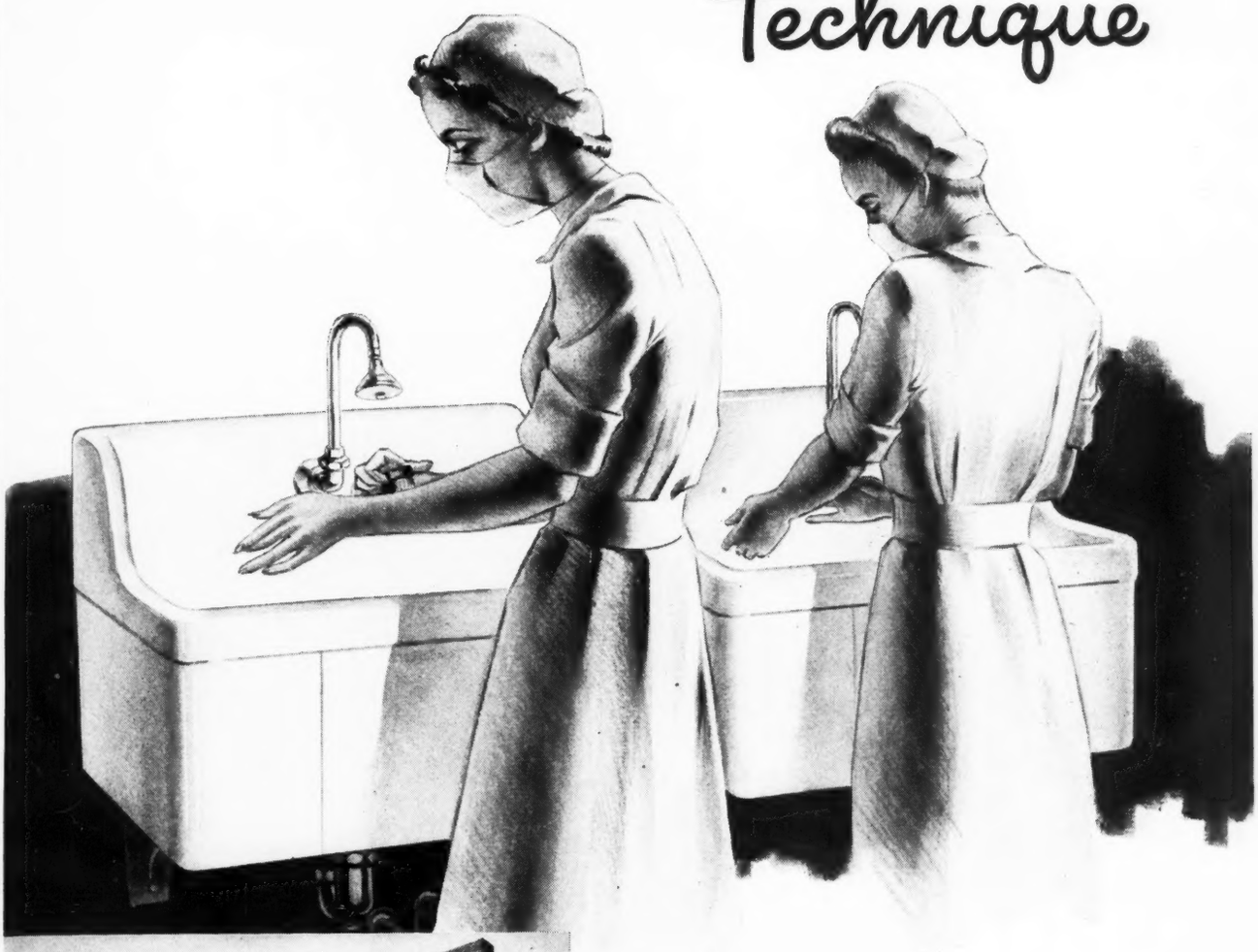
Local hospitals have been asked to carry on the information service that has heretofore been provided largely by the National Nursing Council for War Service and its state and local affiliates. Whether the hospital has a nursing school or not, it is expected to help in this nation-wide task because it has "a vital interest in maintaining the potential supply of nursing service, which the U. S. Cadet Nurse Corps is designed to build up."

Recruitment material will be sent directly to the hospitals and to all state and local nursing councils since they also will continue to be information centers. Volunteers must be enlisted for manning the information desks in hospitals and members of the women's auxiliary of the American Medical Association are eager to help. If hospitals are not prepared to give guidance in the selection of schools, this help can be obtained from the local or national nursing council.

Heads Hospital War Fund Drive

Edward Sovatkin has been appointed chairman of the hospital supplies and laboratory equipment group of the New York Committee of the National War Fund. Benjamin F. Hirsch is vice chairman.

sinks to speed scrub-up technique



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Physician Advocates Formation of Skin Bank for War Wounds, Burns

A skin bank similar to the Red Cross blood banks was proposed at the fourth annual research conference of the Institutum Divi Thomae by Dr. D. Olan Meeker, a New York physician and biochemist. Donated skin could be frozen and held in readiness for grafting on recipients, according to Doctor Meeker. This would eliminate the necessity of stripping skin from other parts of the body of a victim at the time of emergency.

Pointing out that the operation is not excessively painful, Doctor Meeker explained that skin would be removed in layers of from 1/32 to 1/64 inch thick. Skin for grafting can also be removed from cadavers, the speaker asserted, stating that it remains "alive" from two to five days after the person's death.

The preservation of the skin could be obtained by quick freezing at temperatures of from —30°F. to —50°F.

Two Hospitals Given Federal Aid

Presidential approval has been given to two appropriations under the Lanham Act, one of $26,397 for expansion of nurses' training facilities at the Monmouth Memorial Hospital, Long Branch, N. J., and the other, $149,000 for the construction and equipment of a two story and basement addition to the General Hospital, Syracuse, N. Y., for the housing and training of student nurses. The entire Syracuse project will cost an estimated $181,400. The former allotment is a full cost grant for remodeling and equipping a two story garage on the hospital grounds to house 25 student nurses. Both are war public works projects.

Michigan Health Department Sets Up Blood Plasma Program

The blood plasma program of the Michigan department of health, instituted with the cooperation of the American Red Cross, aims to meet both civilian defense requirements and the needs of Michigan physicians for plasma in treatment of their patients.

Local chapters of the Red Cross will cooperate with the state department of health and local communities to make arrangement for bleeding clinics.

Under present arrangements, O.C.D. has priority on all stocks of plasma for the duration of the war. However, a supply of plasma will be reserved at all times for nonmilitary emergencies to be met from the Michigan department of health laboratories. Local distribution of plasma will be the responsibility of some centrally located institution satisfactory to the medical profession and the state department of health.

Each local population group which has held a bleeding clinic will be credited with an amount of plasma equal to the yield from its group of donors. Debited will be amounts sufficient to meet O.C.D. commitments and emergency needs of the state.

Communities which have not provided donors will be able to receive plasma only after they have signified an interest in creating a local supply by making application to hold a bleeding clinic and accumulating a greater amount of plasma than is needed to meet the requirements of the communities that provided the blood.

New U. S. Army Hospital in London

A new United States Army General Hospital was opened recently in London. The center was completely remodeled in three months' time after being damaged by the blitz. The opening of this hospital provides enlisted men and officers of the London staff of the U. S. armed forces with complete hospitalization facilities. The commanding officer is Col. Henry N. Pratt of Boston.

Ohio Maternity Care Funds Cut by Children's Bureau

Funds to pay for the maternity care of service men's wives in Ohio were cut almost in two in September. In the face of an estimated cost of between $198,000 and $222,000 for the month, the state was allotted only $126,000 to pay for the maternity end of the state-federal program.

The U. S. Children's Bureau, which administers the special fund of $4,600,000 appropriated by Congress, informed the Ohio state health director, Dr. R. H. Markwith, that funds were rapidly being exhausted and that no more would be available until Congress completed action.

In the meantime, it was reported that cases were coming in at the rate of 50 a day.

Army Will Pay Ohio Hospitals

An understanding has been reached between the Army Emergency Relief and hospitals of Ohio under which the A.E.R. will pay for the hospital care of dependents of soldiers when there is real need for financial aid to the patient, it has been announced by the State Relations Committee. This agreement does not include care of maternity patients except when the mother is unmarried and the father is a soldier.

Honor Roll

Hospital administrators and assistant administrators serving in the armed forces:

U. S. Navy

George Peck (Ensign), Michael Reese Hospital, Chicago.

U. S. Army

Francis R. Van Buren (Capt.), Children's Memorial Hospital, Cincinnati.

Eloise Lanford, (2nd Lt.) St. Elizabeth's Hospital, Richmond, Va.

R. Z. Thomas Jr. (2nd Lt.), Jackson Memorial Hospital, Miami, Fla.

Southern Baptists Organize

The South-Wide Baptist Hospital Association was organized in Buffalo during the week of the A.H.A. convention. Temporary officers are president, Lawrence A. Payne, Baylor Hospital, Dallas, and secretary, John Dudley, Baptist Hospital, Little Rock, Ark. A meeting for the adoption of a constitution and by-laws, to be prepared by H. L. Dobbs of Baptist Hospital, Louisville, will probably be held in New Orleans in January. There are 20 Baptist hospitals in the 18 southern states and the association is designed to create a greater spirit of cooperation among them and assist in their public relations work, especially among Baptist churches.

California Nurses' Salaries of $140 to $155 Approved

The approved salary level for general duty nurses in California is from $140 to $155 per month, according to an authoritative statement by the War Labor Board representative at a recent meeting of the War Labor Board, tenth region, San Francisco and Los Angeles.

Further, it was stated that the War Labor Board cannot recognize or approve salary increases beyond the prevailing level for any hospital coming under the jurisdiction of the board.

Delegates to the meeting urged that an appeal be made to the War Labor Board in Washington, D. C., to include proprietary hospitals in G.R.O. 26.

Military Surgeons Will Meet

The Association of Military Surgeons of the United States will convene for three days beginning on October 21 at the Bellevue-Stratford Hotel in Philadelphia. This session, marking the fifty-first meeting of the organization, is expected to attract an attendance of 2000 doctors, many of whom have been in active combat. Methods of meeting the new and complicated factors brought on by modern warfare will be discussed. There will be reports on such problems as air evacuation and blast injuries.

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Chicago Rotary Will Aid Cadet Nurse Corps Campaign

Inasmuch as many of the schools of nursing in the hospitals of Illinois have expressed the intention of operating under the U. S. Cadet Nurse Corps, the Chicago Rotary Club is putting its efforts behind the Civilian War Service Committee in its nurse recruitment program rather than continuing to give scholarships.

The committee is made up of organizations, such as the Illinois Chamber of Commerce, the Illinois Medical Society, the Illinois Hospital Association, the Federation of Women's Clubs, League of Nursing Education and other groups of a similar nature.

A headquarters has been established in conjunction with the Illinois State Nurses' Association to direct the newspaper publicity, radio efforts, public assemblies and other efforts that will be employed to attract attention to nursing as a profession.

The Chicago Rotary Club was instrumental in organizing the Civilian War Service Committee and is directing the work of other Rotary Clubs throughout the state in a cooperating campaign. Other service clubs, such as Kiwanis, are also assisting.

In St. Louis, the Rotary Club has announced its intention to continue the financing of the education of student nurses "as long as the program is needed," Louis L. Roth, chairman of the nurse committee, stated, adding that, at the same time, recruiting efforts would be intensified. Mr. Roth stated that only 5 of the 14 schools of nursing in St. Louis have indicated their intention to join the cadet nurse corps program.

Visiting Rule Posters Available

A poster to aid in the enforcement of visiting hours is offered at a nominal price by the Hospital Service Plan Commission of the A.H.A. It is stated that the poster has been tested in Pittsburgh and New York City and has proved effective and economical. Upon request, posters will be individualized for the use of each individual hospital with the particular visiting hours and the name of the institution included.

Max C. Starkloff Honored

The name Max C. Starkloff Memorial has been added to the designation of St. Louis City Hospital in honor of the first health commissioner of St. Louis, who served for thirty-five years under five mayors.

NAMES IN THE NEWS

Administrators

L. P. Longino, superintendent of Milledgeville State Hospital, Milledgeville, Ga., has resigned his position after thirty-seven years' service.

Dr. B. A. Adams, superintendent of San Diego County General Hospital, San Diego, Calif., has resigned to enter private practice.

Ellen L. Stahlnecker has resigned as administrator of Children's Hospital, Akron, Ohio.

Ann Brown Smith, R.N., superintendent of McKinney City Hospital, McKinney, Tex., has retired and **Elsie Louise Delin, R.N.,** superintendent of Maple Knoll Hospital and Home for the Friendless, Cincinnati, has been appointed her successor.

Fern L. Locke, R.N., is acting superintendent of Manchester Memorial Hospital, Manchester, Conn.

Lawrence R. Payne has been appointed superintendent of Baylor University Hospital, Dallas, Tex. Formerly an assistant administrator at Baylor, Mr. Payne now leaves the superintendency of Hillcrest Memorial Hospital, Waco, Tex., to return there.

John W. Rankin has resigned as regional hospital officer of the Fourth Regional Office of Civilian Defense to accept the superintendency of Tuomey Hospital, Sumter, S. C. He succeeds **Charles H. Dabbs.**

H. M. Clymer, of the Wills Hospital, Philadelphia, has accepted the superintendency of Doctors' Hospital, Inc. in that city. He succeeds **Thomas E. Carden.**

Sister Mary Constantine, superintendent of Mount Carmel Hospital, Columbus, Ohio, has recently been appointed Mother Provincial for the eastern province of the Sisters of the Holy Cross. **Sister Mary Alfreda,** superintendent of St. Agnes Hospital, Fresno, Calif., succeeds Sister Mary Constantine at Mount Carmel.

Francis R. Van Buren, superintendent of Children's Hospital, Cincinnati, is now a captain in the Medical Administrative Corps and is stationed at Camp Grant. During Capt. Van Buren's absence **William T. Bahlman,** former purchasing agent, will serve as superintendent.

Elizabeth Dixon, superintendent of Irvington House, Cardiac Home, Irvington, N. Y., has resigned.

Fay Simon is the new superintendent of Monticello Hospital, Monticello, N. Y., succeeding **Sheila Neimark.**

Coming Meetings

Oct. 5-7—National Safety Council, Chicago.

Oct. 12-14—American Public Health Association, New York City.

Oct. 17-22—Inter-American Radiological Congress, Buenos Aires, Argentina.

Oct. 19-22—American Dietetic Association, Hotel William Penn, Pittsburgh.

Oct. 21—Association of Military Surgeons of the United States, Bellevue-Stratford Hotel, Philadelphia.

Oct. 21-22—Maryland-District of Columbia Hospital Association, Hotel Washington, Washington, D. C.

1944

Feb. 18-20—National Association of Methodist Hospitals and Homes, Claypool Hotel, Indianapolis.

March 15-17—New England Hospital Assembly, Hotel Statler, Boston.

April 25-27—Ohio Hospital Association, Neil House, Columbus, Ohio.

D. U. Phillips has been appointed superintendent of the Christian Welfare Hospital, East St. Louis, Ill., to succeed **Edward Rowlands,** now superintendent of Memorial Hospital, Colorado Springs, Colo.

Mildred Taylor, R.N., has resigned as administrator of North Adams Hospital, North Adams, Mass. **Isabel M. Baird,** a recent graduate in hospital administration from the University of Toronto, has been named Miss Taylor's successor.

Genevieve Jeffrey has been appointed superintendent, Lake Forest Hospital, Lake Forest, Ill.

John A. Lindner formerly superintendent, Perth Amboy General Hospital, Perth Amboy, N. J., has been appointed director, Doctors Hospital, Washington, D. C., succeeding **O. K. Fike.**

Whitelaw H. Hunt has been appointed superintendent, Charleroi-Monessen Hospital, Charleroi, Pa.

Robert Williams has been appointed superintendent, Lincoln General Hospital, Lincoln, Neb. Mr. Williams was formerly identified with the Children's Hospital in Denver and has lately been located in Honolulu.

Charles B. Allen, newly appointed superintendent of St. Luke's Hospital, Newburgh, New York, was married recently to **Mary Janet McGeachin** who was formerly secretary to **Charles C. Roswell** of the United Hospital Fund, New York City.

Department Heads

Harriet Smith, former superintendent of nurses at Harborview Hospital, Seattle, Wash., will assume the position of superintendent of nurses and director of the school of nursing at Wesley Hospital, Chicago, on January 1. Between

the Seattle General-University of Washington job and the new Wesley post, Miss Smith is acting as field officer for the Procurement and Assignment Service. She is a graduate of Mount Holyoke College.

Minnie Goodnow has been appointed director of nursing at Joseph H. Pratt Diagnostic Hospital, Boston.

Eloise Lanford, superintendent of St. Elizabeth's Hospital, Richmond, Va., and director of the school of nursing there, has left to become a second lieutenant in the Army Nurse Corps.

Fannie Montgomery, superintendent of Riverside Hospital, Paducah, Ky., has resigned because of ill health. **S. A. Ruskjer,** for the last eight years superintendent of William Mason Memorial Hospital, Murray, Ky., will assume the superintendency of Riverside Hospital in addition to his duties at Murray.

Neva R. Pew, R.N., superintendent of Millersburg Hospital, Millersburg, Ohio, for the last seven years, has resigned to become director of nurses and assistant administrator of Riverside Hospital, Paducah, Ky.

E. L. Bailey, general manager of Keys-Houston Clinic Hospital, Murray, Ky., has resigned to accept a similar position at Union County Hospital, Morgansfield, Ky.

Mrs. Adele B. Frey, who has been executive housekeeper of the Kahler Corporation group of hotels and hospitals in Rochester, Minn., since May 1, has returned to her former position as executive housekeeper of the Stevens Hotel, which is scheduled to reopen November 1.

Mrs. V. J. Trimble has been appointed executive housekeeper at Grace Hospital, New Haven, Conn., to replace **Mrs. Vera Frey,** who recently resigned.

Melba King, R.N., of the Medical Department of the Naval Cadet Training School, Murray, Ky., is now a day supervisor of Riverside Hospital, Paducah, Ky.

Miscellaneous

Mary C. Jarrett, secretary of the health division, Welfare Council, New York City, has resigned the post she has held with that organization for eighteen years.

Homer C. Washburn, founder and dean of the college of pharmacy at the University of Colorado, has retired.

Eleanor Crook has resigned from the public information staff of the National Nursing Council for War Service, Inc., to be with the Associated Hospital Service of New York City as a member of its public relations department.

Minnie E. Pohe, director of Stanford University School of Nursing and the nursing service of Stanford University Hospitals, San Francisco, has been appointed assistant director in the division of nurse education of the U. S. Public Health Service.

R. Z. Thomas Jr., business administrator of Jackson Memorial Hospital, Miami, Fla., has been appointed second lieutenant in the Medical Administrative Corps and has reported for duty at Carlisle Barracks, Carlisle, Pa.

Russell L. Dicks, D.D., will report to Wesley Hospital, Chicago, on January 1, for duty as chaplain. Doctor Dicks was formerly chaplain at Presbyterian Hospital, Chicago. More recently he has served as pastor of the Highland Avenue Presbyterian Church, Dallas, Tex., and is now with the Federal Council of Churches and the U.S.O. training Army and Navy chaplains in personnel work.

Deaths

George Goodhue Kineon, medical director and superintendent of Ohio State Hospital for Epileptics, Gallipolis, Ohio, died recently.

Clarence T. Johnson, former superintendent of Washington Boulevard Hospital, Chicago, died September 16.

Strike by Illinois State Hospital Employes Is Averted

A strike by employes of state hospitals at Kankakee and Manteno, Ill., was averted August 31 when the Illinois Public Welfare Department agreed to review individually the charges of the employes that they were denied a "just application of the wage and classification bill" passed by the last legislature.

Complaints were submitted by 1300 of the 3700 employes of the department of public welfare. In order to avoid any charges of discrimination, the names of 27 institutions involved were drawn by lot and the complaints will be considered in the order in which the institutions were drawn.

State officials announced that if employes are not satisfied with the decisions rendered in their cases the department of welfare will discuss each individual case with Mrs. Helen Sewell, general representative of the American Federation of State, County and Municipal Employees (A. F. of L.), in an attempt to reach a settlement.

Springfield Hospital Opens

Formal opening of the new Memorial Hospital of Springfield, Springfield, Ill., was celebrated with an "open house" on September 26.

Illinois Offers O.T. Course

A four year curriculum in occupational therapy, conforming with the most advanced practices advocated by the American Medical Association and leading to a bachelor of science degree in occupational therapy, has been set up by the University of Illinois. Instruction will begin in October. The curriculum is organized under the University of Illinois College of Medicine. In addition, eight other departments will contribute specially designed courses.

Wacs Trained at Hospital School

More than 1000 Wacs have been enrolled for training and service in the Army Medical Department at the Army-Navy Hospital School, Hot Springs, Ark. Each Wac will be given training in one of five courses. Courses for training x-ray technicians are of three months' duration; those for training medical and surgical technicians are of two months' duration.

Mrs. Hyde to Edit Bulletin

Mrs. Florence Slown Hyde has been requested to continue for another year as editor of the Illinois Hospital Association's monthly *News Bulletin*. Mrs. Hyde plans to develop a public education program in the interest of Illinois hospitals.

Bristol Opens Addition

Although war-time restrictions on building materials curtailed the original building program of Bristol Hospital, Bristol, Conn., the hospital on September 19 dedicated its new "war-time addition," which will add 50 beds to its facilities. The addition consists of a one story and basement extension with a temporary roof and was so constructed that three more stories can be added in the postwar period. Plans and specifications for the expansion have already been drawn. Lanham Act funds totaling $67,641 were allotted for the project which cost approximately $150,477.

New Jersey Hospital Builds Wing

Contracts have been let for a 6 bed addition to the New Jersey Orthopaedic Hospital and Dispensary at Orange, N. J., to cost less than $10,000 and to be ready for occupancy December 1. The addition will provide one 4 bed room and one 2 bed room and some necessary storage rooms.

$222,000 Raised for Nurses' Home

Ketchum, Inc., financial campaign organization of Pittsburgh, has announced that it has recently completed a campaign for the Pittsburgh Hospital, raising $222,000 for a new nurses' home.

"FOR GOODNESS' SAKE, QUIT STAMPING YOUR FEET!"

EXAGGERATION? Yes, of course! But when people are sick and nervous even the slightest sound is greatly exaggerated. That's why hospitals stress the importance of *quiet* in getting well. Today, with overcrowding and greater activity on every floor, patients are being subjected to an increased volume of harmful noise. This slows up recoveries and makes the work of depleted staffs more difficult.

However, there *is* a way you can remedy the situation as hundreds of leading hospitals have done. Install the soothing quiet of Acousti-Celotex. This famous sound conditioning material produces a restful hush that will relax nerves, induce sleep, hasten recovery. It will also help your staff do its important job with calm efficiency.

Acousti-Celotex is America's most widely used sound conditioning material. It can be quickly and quietly applied. It can be repeatedly painted. Why not start first with a corridor or diet kitchen? Let results show you what can be done with any other noise problem you may have. Talk with the Acousti-Celotex distributor in your territory. He is headquarters for sound conditioning and a member of the world's most experienced organization. His advice is yours without obligation and *he guarantees results.* If you cannot locate him, a note to us will bring him to your desk.

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Chicago, Illinois

Please send me your free booklet, "25 Answers to Questions on Celotex Sound Conditioning."

Hospital.....

Name.....

Address.....

City..... *State*.....

Use Oleomargarine Without Color

Institutions are cautioned against using oleomargarine, except in its natural state *without color added*. According to reports from the Joint Purchasing Corporation, New York City, there is a federal law which specifies that anyone using oleomargarine to which color has been added is subject to the manufacturers' tax of $600 per year.

Radiologists to Meet in Argentina

The first Inter-American Radiological Congress will open in Buenos Aires, Argentina, on October 17 and continue through October 22. The congress will be held in the new faculty building of the Policlinica San Martin. Dr. Jose F. Merlo Gomez, president of the Argentine Radiological Society, will serve as president of the congress.

Bellevue to Add R. T. C.

A grant of $290,000 to reconstruct one of the dormitory buildings at Bellevue Hospital, New York City, as a rapid treatment center for venereal diseases and another grant of $272,718 for its maintenance have been approved by the Federal Works Agency. A convalescent rehabilitation camp on Welfare Island is also included in the project.

State to Supervise Infirmary

In accordance with a recent agreement, the physical plant of the Illinois Eye and Ear Infirmary will henceforth be under the direction of the state department of public welfare and all professional activities and personnel connected with such activities will be under the direction of the University of Illinois College of Medicine. Dr. Harry S. Gradle, chief of staff of Illinois Eye and Ear Infirmary, under the new setup becomes professor of ophthalmology at the medical school.

Funds Given for Penicillin Study

A three year grant of $25,000 a year was made recently by the Upjohn Company, Kalamazoo, Mich., to the University of Illinois for the academic study of the structural composition and possible synthesis of penicillin. This new research project will be under the direction of Prof. Herbert E. Carter of the department of bio-chemistry at Urbana.

Receive Bishop's Cross

The Bishop's Cross for Distinguished Service was recently awarded to O. J. Murie, superintendent of St. John's Hospital, Jackson, Wyo., and Mrs. Josephine C. Brown, chief nurse and assistant superintendent.

Plasma Saves Wreck Victims

The lives of many persons injured in the train wreck at Wayland, New York, were saved by blood plasma from a local hospital and from an O.C.D. plasma reserve depot. The work was made possible by prompt action on the part of the O.C.D. Emergency Medical Service and the Civil Air Patrol, according to James M. Landis, director of civilian defense.

Zarate Visits American Hospitals

Manuel F. Zarate, a fellow of the Office of the Coordinator of Inter-American Affairs and superintendent of the Hospital Santo Tomas in Panama City, Panama, is in America on a study tour in hospital administration. Mr. Zarate formerly studied in France, England and Italy. The Hospital Santo Tomas of which he is superintendent is the leading general hospital in Panama.

Cancer Hospital Reports on Service

Despite the major difficulties of wartime administration, Memorial Hospital for the Treatment of Cancer and Allied Diseases, New York City, reports the largest service registered in its history. From 1940 to 1942, 13,629 patients were admitted. Operations totaled 11,143. In the children's cancer ward, 319 patients received treatment.

Wartime Cleaning Problems?

Here are 14 right answers!

We don't have to tell you that keeping your entire establishment clean in times like these is no easy job. The thousands of "HelpWanted" signs in windows everywhere are mute testimony that your problems are many and real.

From our world's largest industrial research laboratories comes a wealth of experience and skill—so you may have the *right* cleaning product for *every kind* of cleaning job.

Here are 14 right answers to war-burdened operators —for the quick, economical HELP you need.

Ask "Swift" for prices and service. 450 nationwide stock points keep supplies near you.

SWIFT & COMPANY

Division of Commercial Soaps and Detergents
General Offices: Chicago, Illinois

Swift & Company
Cleaning and Laundering Supplies for Restaurants, Hotels, Cafeterias, Institutions

For General Use

Sunbrite Cleanser—all-purpose cleanser for every scouring need.
Amazon Detergent—institution-grade cleanser for all heavy-duty scouring, scrubbing, mopping.
Pride Washing Powder—free-lathering soap powder for all heavy-duty washing, mopping.
Flexo—soap saver, water softener and all-purpose cleaner for finest surfaces.

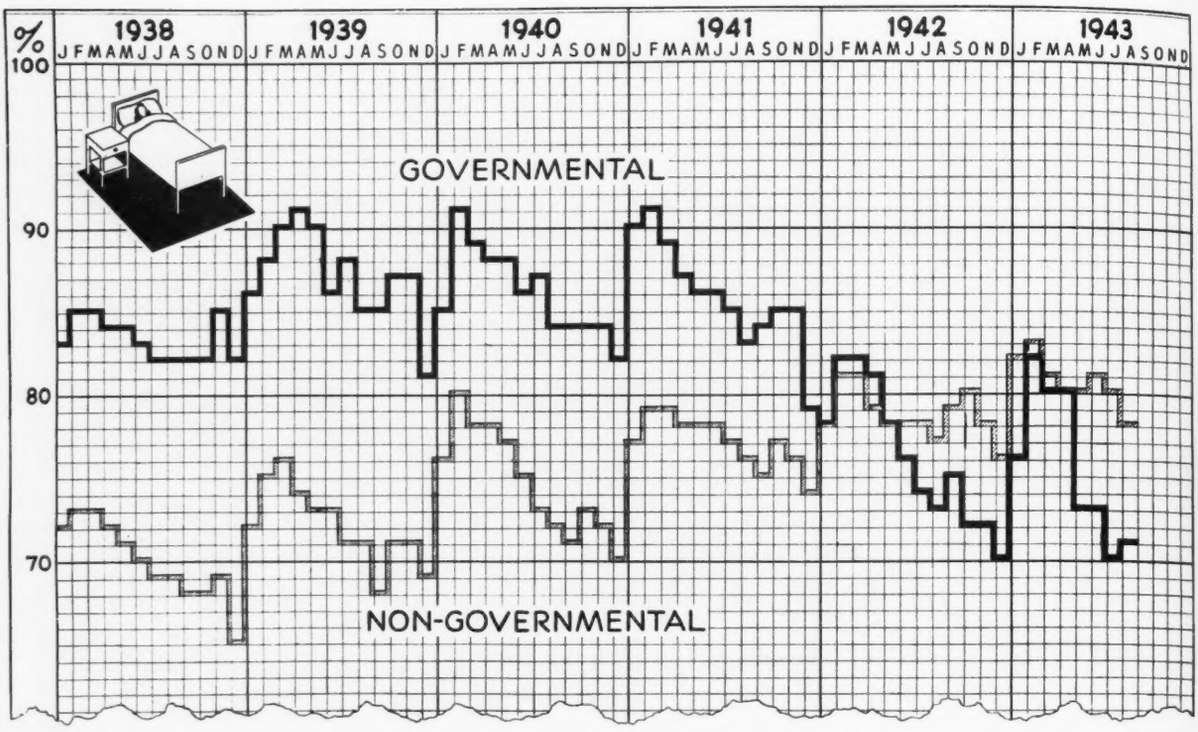
For Dishwashing

Keystone Dishwasher—noted for grease-emulsifying qualities when used in dishwashing machines.
Keystone China Kleen—especially compounded for machine dishwashing, with unusually hard water.
F. G. (First Grade) Washing Powder—high soap content, for hand dishwashing.
Keystone Aluminum Cleanser—for cleaning aluminum utensils, pans, cooking molds, beer coils.

For the Laundry

White Ribbon Flakes and Powder—for power laundry use, these commercially neutral products are the highest type of tallow soap.
Glory Soap Flakes and Powder—contain a slight builder.
Guaranteed Laundry Powder—completely built powdered soap for use dry on the wheel.
Formula "S" Powder—for low-temperature washing.
Keystone Laundry Soda—neutral soda for soap building, making bleach, and water softening.
Keystone Laundry Compound—for building stock soap solutions or using with powdered dry soap.

Voluntary Hospital Occupancy Eases Off



August occupancy in voluntary general hospitals dropped two points from the July figure of 80 per cent but still continued much higher than the occupancy in governmental general hospitals. The latter reached a low point of 70 per cent in July and advanced only to 71 per cent in August.

New construction for the period from August 23 to September 20 fell off with only 24 reports of which 18 gave costs. The total involved was $5,165,000, bringing the year-to-date total to $100,713,000. Postponed projects reduce this latter figure to $80,150,000.